DOCUMENT RESUME

ED 465 735 SP 040 887

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TITLE Someone at School Has AIDS. 2001 Edition.
INSTITUTION National Association of State Boards of Education, Alexandria, VA.
SPONS AGENCY Centers for Disease Control (DHHS), Atlanta, GA. Div. of Adolescent and School Health.
PUB DATE 2001-00-00
NOTE 97p.
CONTRACT U87-CCU310215-02
AVAILABLE FROM National Association of State Boards of Education, 277 South Washington Street, Suite 100, Alexandria, VA 22314 ($15). Tel: 703-684-4000; Tel: 800-220-5183 (Toll Free); Fax: 903-836-2313; e-mail: boards@nasbe.org; Web site: http://www.nasbe.org/catalog.html.
PUB TYPE Guides - Non-Classroom (055)
EDRS PRICE EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; Athletics; Attendance; Comprehensive School Health Education; Elementary Secondary Education; Equal Opportunities (Jobs); Health Promotion; Privacy; *School Policy; Staff Development
IDENTIFIERS Risk Reduction

ABSTRACT

This policy guide explains that every state and school district needs policies addressing serious issues raised by human immunodeficiency virus (HIV) infection. Chapter 1, "Developing Policy," discusses why policies are valuable, at what level policy belongs, and whether policies should be specific to HIV. Chapter 2, "Policy Recommendations," presents a preamble (the state/district/school shall strive to protect the safety and health of children and youth in their care, as well as their families, school employees, and the general public, and staff members shall cooperate with the public health authorities to promote these goals). It goes on to present nine areas of focus: school attendance, employment, privacy, infection control, HIV and athletics, HIV prevention education, related services, staff development, and general provisions. Chapter 3, "Engaging the Community," focuses on: a proactive communications plan; educating the community; a crisis management plan; and a plan for during a crisis (controversy management). It discusses whether school leaders should reveal that someone has HIV infection and what to do if a family wants to go public. The five appendixes include selected resources, state information sources, HIV transmission facts, suggested policy terms, and federal disability rights laws. (Contains 22 references.) (SM)

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Someone at School has AIDS.

2001 Edition

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A COMPLETE GUIDE TO EDUCATION POLICIES CONCERNING HIV INFECTION

SP040887

These organizations recommend this document to their readers:

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American School Health Association
Association for Supervision and Curriculum Development
Association of State and Territorial Health Officials
Council for Exceptional Children
Council of Chief State School Officers
Council of Great City Schools
National Alliance of State and Territorial AIDS Directors
National Association for Sport and Physical Education
National Association of Elementary School Principals
National Association of School Nurses
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National Education Association
National Federation of State High School Associations
National Middle School Association
National Nursing Coalition for School Health
National PTA
National School Boards Association
National School Health Education Coalition
Ryan White Foundation

Someone at School has AIDS.

A COMPLETE GUIDE TO EDUCATION POLICIES CONCERNING HIV INFECTION

First edition 1989
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Second edition 1996
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Resources and statistics updated 2001

This publication was developed under a cooperative agreement with the Division of Adolescent and School Health of the U.S. Centers for Disease Control and Prevention; grant #U87/CCU310215-02. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

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Someone at School has AIDS: A Complete Guide to Education Policies Concerning HIV Infection

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NASBE Healthy Schools Network

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- call (800) 220-5183
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Related publications available from NASBE:

- ☆ *The National Youth Summit on HIV Prevention and Education, May 6–9, 1995: Summary Report and Recommendations;* also, *Video Highlights* (VHS, 45 min.)
- ☆ *Fit, Healthy, and Ready to Learn: A School Health Policy Guide*
- ☆ *How Schools Work and How to Work with Schools: A Guide for Health and Social Services Professionals*
- ☆ *Building Business Support for Coordinated School Health Programs: An Action Guide* (includes CD-ROM)
- ☆ *The Impact of Adolescent Pregnancy and Parenthood on Educational Achievement: A Blueprint for Education Policymakers' Involvement in Prevention Efforts*
- ☆ *Schools Without Fear: Report of the NASBE Study Group on Violence and Its Impact on Schools*
- ☆ *Winning Ways: Creating Inclusive Schools, Classrooms, and Communities*

Cover design by Brecher & Tagami, Unlimited

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EXECUTIVE SUMMARY

Every state and school district needs policies that address serious issues raised by HIV infection. Sound policies provide essential guidance to educators; reassurance to families, students, and school staff members; legal protection for schools; and support for people with the virus. Well drafted and administered, they can also help to prevent or contain controversy.

Various laws establish parameters for policy options concerning HIV infection, notably the Americans with Disabilities Act and the Individuals with Disabilities Education Act. The policy development process should involve medical and legal experts and those affected by the policy, and welcome diverse points of view from the community. Locally developed procedures should accompany general statements of policy.

Education leaders need to actively communicate and engage in dialogue with the community about HIV-related school policies and procedures. Educators ought to work with their local health department to educate the public about medical and legal issues concerning HIV infection.

SAMPLE POLICY

Preamble

p. 7

State/District/School shall strive to protect the safety and health of children and youth in our care, as well as their families, our employees, and the general public. Staff members shall cooperate with public health authorities to promote these goals.

The evidence is overwhelming that the risk of transmitting human immunodeficiency virus (HIV) is extremely low in school settings when current guidelines are followed. The presence of a person living with HIV infection or diagnosed with acquired immunodeficiency syndrome (AIDS) poses no significant risk to others in school, day care, or school athletic settings.

1. School Attendance

p. 11

A student with HIV infection has the same right to attend school and receive services as any other student, and will be subject to the same rules and policies. HIV infection shall not factor into decisions concerning class assignments, privileges, or participation in any school-sponsored activity.

School authorities will determine the educational placement of a student known to be infected with HIV on a case-by-case basis by following established policies and procedures for students with chronic health problems or students with disabilities. Decision makers must consult with the student's physician and parent or guardian; respect the student's and family's privacy rights; and reassess the placement if there is a change in the student's need for accommodations or services.

School staff members will always strive to maintain a respectful school climate and not allow physical or verbal harassment of any individual or group by another individual or group. This includes taunts directed against a person living with HIV infection, a person perceived as having HIV infection or a person associated with someone with HIV infection.

2. Employment

p. 18

The *State/District/School* does not discriminate on the basis of HIV infection or association with another person with HIV infection. In accordance with the Americans with Disabilities Act of 1990, an employee with HIV infection is welcome to continue working as long as he or she is able to perform the essential functions of the position, with reasonable accommodation if necessary.

3. Privacy

p. 23

Pupils or staff members are not required to disclose HIV infection status to anyone in the education system. HIV antibody testing is not required for any purpose.

Every employee has a duty to treat as highly confidential any knowledge or speculation concerning the HIV status of a student or other staff member. Violation of medical privacy is cause for disciplinary action, criminal prosecution, and/or personal liability for a civil suit.

No information regarding a person's HIV status will be divulged to any individual or organization without a court order or the informed, written, signed, and dated consent of the person with HIV infection (or the parent or guardian of a legal minor). The written consent must specify the name of the recipient of the information and the purpose for disclosure.

All health records, notes, and other documents that reference a person's HIV status will be kept under lock and key. Access to these confidential records is limited to those named in written permission from the person (or parent or guardian) and to emergency medical personnel. Information regarding HIV status will not be added to a student's permanent educational or health record without written consent.

4. Infection Control

p. 28

All employees are required to consistently follow infection control guidelines in all settings and at all times, including playgrounds and school buses. Schools will operate according to the standards promulgated by the U.S. Occupational Health and Safety Administration for the prevention of blood-borne infections. Equipment and supplies needed to apply the infection control guidelines will be maintained and kept reasonably accessible. *Designate* shall implement the precautions and investigate, correct, and report on instances of lapse.

A school staff member is expected to alert the person responsible for health and safety issues if a student's health condition or behavior presents a reasonable risk of transmitting an infection.

If a situation occurs at school in which a person might have been exposed to an infectious agent, such as an instance of blood-to-blood contact, school authorities shall counsel that person (or, if a minor, alert a parent or guardian) to seek appropriate medical evaluation.

5. HIV and Athletics

p. 33

The privilege of participating in physical education classes, athletic programs, competitive sports, and recess is not conditional on a person's HIV status. School authorities will make reasonable accommodations to allow students living with HIV infection to participate in school-sponsored physical activities.

All employees must consistently adhere to infection control guidelines in locker rooms and all play and athletic settings. Rulebooks will reflect these guidelines. First aid kits must be on hand at every athletic event.

All physical education teachers and athletic program staff will complete an approved first aid and injury prevention course that includes implementation of infection control guidelines. Student orientation about safety on the playing field will include guidelines for avoiding HIV infection.

6. HIV Prevention Education

p. 36

The goals of HIV prevention education are to promote healthful living and discourage the behaviors that put people at risk of acquiring HIV. The educational program will:

- be taught at every level, Kindergarten through grade twelve;
- use methods demonstrated by sound research to be effective;
- be consistent with community standards;
- follow content guidelines prepared by the Centers for Disease Control and Prevention (CDC);
- be appropriate to students' developmental levels, behaviors, and cultural backgrounds;
- build knowledge and skills from year to year;
- stress the benefits of abstinence from sexual activity, alcohol, and other drug use;
- include accurate information on reducing risk of HIV infection;
- address students' own concerns;
- include means for evaluation;
- be an integral part of a coordinated school health program;
- be taught by well-prepared instructors with adequate support; and
- involve parents and families as partners in education.

Parents and guardians will have convenient opportunities to preview all HIV prevention curricula and materials. School staff members shall assist parents or guardians who ask for help in discussing HIV infection with their children. If a parent or guardian submits a written request to a principal that a child not receive instruction in specific HIV prevention topics at school, and assures that the topics will be discussed at home or elsewhere, the child shall be excused without penalty.

The education system will endeavor to cooperate with HIV prevention efforts in the community that address out-of-school youth and youth in situations that put them at high risk of acquiring HIV.

7. Related Services

p. 47

Students will have access to voluntary, confidential, age and developmentally appropriate counseling about matters related to HIV infection. School administrators will maintain confidential linkage and referral mechanisms to facilitate voluntary student access to appropriate HIV counseling and testing programs, and to other HIV-related services as needed. Public information about resources in the community will be kept available for voluntary student use.

8. Staff Development

p. 53

All school staff members will participate in a planned HIV education program that conveys factual and current information; provides guidance on infection control procedures; informs about current law and state, district, and school policies concerning HIV; assists staff to maintain productive parent and community relations; and includes annual review sessions. Certain employees will also receive additional specialized training as appropriate to their positions and responsibilities.

9. General Provisions

p. 57

On an annual basis, school administrators will notify students, their family members, and school personnel about current policies concerning HIV infection, and provide convenient opportunities to discuss them. Information will be provided in major primary languages of students' families.

This policy is effective immediately upon adoption. In accordance with the established policy review process, or at least every three years, __*designate*__ shall report on the accuracy, relevance, and effectiveness of this policy and, when appropriate, provide recommendations for improving and/or updating the policy.

PREFACE

The prospect of students with HIV infection or AIDS attending school is sometimes controversial. Schools and communities have suffered public relations and legal nightmares; children and their families have been treated as outcasts out of concern for other children's safety. Such stories still occasionally occur. Yet, a great many communities across America are demonstrating an ability to respond with compassion and understanding to people with HIV infection.

This guide aims to provide guidance on HIV-related school policies that are medically, legally, and educationally sound.

Policies that provide clear guidance are critical to a school's ability to deal effectively with HIV infection. The need to balance a number of complex factors—the concerns of families, staff, and community members; the needs of people with HIV infection; legal requirements; public health recommendations; and compassion—make policymaking a challenge. When problems develop, it is usually because school authorities do not understand the facts about HIV and AIDS, lack procedural guidelines, or are not prepared to deal with peoples' concerns. Education decision makers need accurate answers to practical questions. The intent of this guide is to provide the necessary information.

The good news is that a great many states, school districts, schools, and day care centers *have* established workable policies with little trouble. A common element among the success stories is that sound policies were in place before they were needed.

But even if a school already has policies, the challenge is not over. Policies adopted just a few years ago might not be adequate to deal with today's issues. New laws, scientific data, and lessons from experience continually emerge. This second edition of *Someone at School has AIDS* also aims to help those who are revising existing policies.

As fear subsides in a community and people become accustomed to the presence of a student or staff member with HIV infection, they often view the situation differently: as simply another medical problem that schools can handle in the same way they handle other serious health conditions. This guide espouses that matter-of-fact approach.

MISSOURI:
Revising policies

The continuing expansion of medical knowledge about communicable diseases, and expanding statutory and case law on the rights of individuals who may have the diseases, make it imperative that local boards of education routinely review their policies and procedures to be sure they are both legal and effective.

The State Board of Education recommends that all local boards of education review their policies and procedures and make adjustments where necessary.

1995

Terminology

The term "HIV infection" is used here broadly to mean every stage of infection and illness, including a diagnosis of AIDS. Education policy usually does not need to distinguish between HIV infection and AIDS.

Background of this guide:

More than 20,000 copies of the first edition of *Someone at School has AIDS* were distributed. Developed in 1988 by Katherine Fraser with many collaborators, its primary purpose was to help schools calm widespread fears so they could get on with the business of education. A large number of states and school districts shaped their response to the HIV epidemic with its help.

Recognizing the possible need for an update, the National Association of State Boards of Education (NASBE) surveyed a broad range of practitioners for their views. NASBE found that most of the original policy recommendations in *Someone at School has AIDS* were still considered valuable and practical, but also heard many suggestions for improvement.

What is different?

This edition expands on several topics mentioned briefly in the original, including school athletics, effective HIV prevention education, and HIV-related services.

A major substantive change concerns the evaluation process used to determine student placement. Rather than suggesting that schools establish a distinct procedure to assess the situation of each student with HIV infection, ill or not, NASBE now suggests that evaluation is only necessary when a student has special needs. Schools can use the same procedures that should already be in place regarding other students with disabilities or chronic health conditions.

Several drafts of this document were reviewed by more than fifty people with relevant experience and qualifications. It was also reviewed for accuracy by the Centers for Disease Control and Prevention (CDC).

Ryan White

Excerpts of testimony before the National Commission on AIDS

"I came face to face with death at 13 years old. I was diagnosed with AIDS: a killer. Given six months to live and being the fighter that I am, I set high goals for myself. It was my decision to live a normal life, go to school, be with my friends, and enjoy day to day activities. It was not going to be easy.

"The school I was going to said they had no guidelines for a person with AIDS. The school board, my teacher, and my principal voted to keep me out of the classroom for fear of someone getting AIDS from me by casual contact. Rumors of sneezing, kissing, tears, sweat and saliva spreading AIDS caused people to panic.

"We began a series of court battles for nine months, while I was attending classes by telephone. Eventually, I won the right to attend school, but the prejudice was still there. Listening to medical facts was not enough. People wanted 100% guarantees. Parents of twenty students started their own school.

"Discrimination, fear, panic and lies surrounded me. I became the target of jokes; there were lies about me biting people, spitting on vegetables and cookies, and urinating on bathroom walls. My school locker was vandalized inside and folders were marked 'fag' and other obscenities. I was labeled a troublemaker, my Mom an unfit mother, and I was not welcome anywhere. People would get up and leave so they would not have to sit anywhere near me. Even at church, people would not shake my hand."

National news reports and a television movie brought Ryan White's story to the attention of the American public. After three years of hostility his family moved to a supportive school and community, Cicero, Indiana, where he became "a normal happy teenager" and "just one of the kids." He remained a vocal advocate for AIDS prevention until his death in April 1990 at the age of nineteen. Congress honored his courage by naming a major piece of legislation The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Since 1988, when *Someone at School has AIDS* was first written...

- ☆ The number of children and adolescents infected with HIV is much greater, in rural and suburban locations as well as inner cities. In some areas every school probably has several students or staff members living with HIV infection.
- ☆ A broader range of people are infected by HIV, and directly affected by it.
- ☆ Many more children are attending school who were born with HIV infection and have disabilities.
- ☆ HIV is disrupting the lives of many more families. A student without HIV infection might have a parent or relative who is seriously ill or has died from complications of AIDS.
- ☆ The federal government has adopted additional laws, regulations, and guidance documents, notably the Americans with Disabilities Act, and workplace protection standards from the U.S. Occupational Safety and Health Administration.
- ☆ Many national organizations and government agencies have produced valuable guidance documents useful to different audiences.
- ☆ Terminology and language have evolved, along with changing perspectives and attitudes.

Death Frees Parents to Talk About Son's Struggle With AIDS

St. Louis Post-Dispatch, October 13, 1995

Mark [deleted]'s family was forced to flee [deleted] two years ago due to a rumor that a student at school had AIDS. Mark, who was born three months prematurely, contracted the disease from a blood transfusion when he was about five weeks old. His family survived five attempts to burn down their house; furthermore, words such as "AIDS," "Burn," and "Leave" were scrawled on the outside of their home. When Mark began school, his parents informed school and health officials of his disease, although they were not legally required to do so. The officials guarded their privacy, but a television newscast reported the story in 1992, which resulted in bomb threats and arson attempts against the family. Mark died in October 1995.

A Snapshot of the Epidemic in the United States

Children under 13:

- ☆ As of June 30, 2000, CDC counted 3,664 children under age 13 currently living with AIDS, the advanced stage of HIV infection.[1] It is not known how many of these children were attending school.
- ☆ Another 1,911 children were living with HIV but had not progressed to a diagnosis of AIDS in the 34 states and territories that counted such cases.[1] California, Illinois, Maryland, New York, Pennsylvania, and Puerto Rico were among the jurisdictions that did not count cases of HIV infection in this age group, so the national total is undoubtedly higher.
- ☆ Because of effective treatments to prevent the transmission of HIV from mother to infant, the number of new cases of pediatric AIDS declined year by year throughout the 1990's.[2]

Adolescents and young adults:

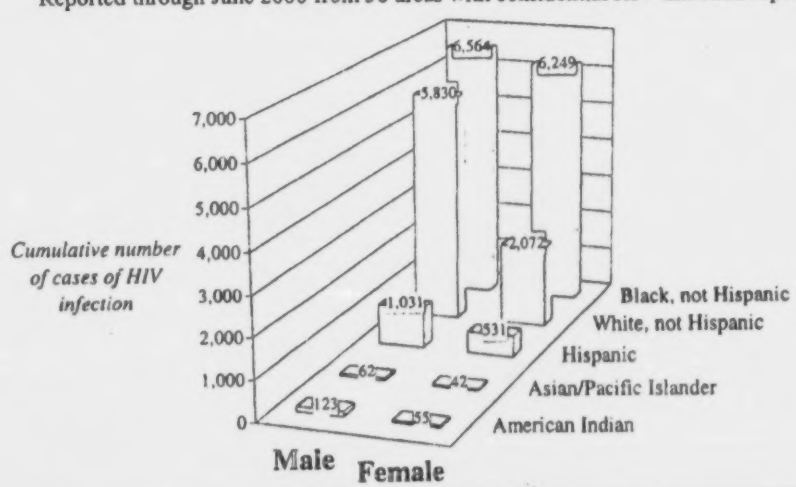
- ☆ Since the beginning of the epidemic through June, 2000, 3,865 adolescents ages 13–19 have been diagnosed with AIDS.[1] Another 26,518 cases have been diagnosed in the 20–24 age group. Given the time between initial infection and an AIDS diagnosis, most of these probably acquired HIV while teenagers.
- ☆ A total of 5,263 adolescents ages 13–19 have been found to have HIV infection in the 34 states and territories that report such cases, but again, this does not include several important jurisdictions.[1] Notably, more adolescent girls were found to be infected than boys.
- ☆ From the beginning of the epidemic through June, 2000, 17,526 young adults ages 20–24 were reported to have HIV infection in those areas where such cases were counted.[1] Added together, young people ages 13–24 have accounted for 17 percent of *all* reported cases of HIV infection.

African Americans:

- ☆ Representing an estimated 12 percent of the total U.S. population, African Americans make up almost 37 percent of all AIDS cases.[3] The 1999 rate of reported AIDS cases among African Americans was more than 2 times greater than the rate for Hispanics and 8 times greater than the rate for whites. In 25 states with integrated HIV and AIDS reporting systems, 65 percent of the HIV diagnoses among young people 13–24 were among African Americans during the period January 1996–June 1999. African American children represent 65 percent of all reported pediatric AIDS cases in 1999.

Cases of HIV Infection Among Youth Ages 13–24, by Sex and Race/Ethnicity

Reported through June 2000 from 36 areas with confidential HIV infection reporting[1]



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Chapter I: DEVELOPING POLICY

Policies, and the process used to develop or revise them, are valuable for:

- ☆ *Leadership*: The process enables leaders to demonstrate the importance of knowledge, principle, and experience to the making of sound policy.
- ☆ *Engaging the public:* A good process for developing policy takes into consideration all expressed points of view.
- ☆ *Guidance*: Policies based on current scientific, medical, and legal information clarify issues and lay out options for action. They anticipate potentially difficult situations, and reduce the chances of haphazard responses in urgent situations.
- ☆ *Reassurance:* Students, parents, and school employees need to know that safety and health are important concerns of school authorities and that sensitive matters will be handled in a systematic, professional way.
- ☆ *Support:* To practice their professions with confidence, teachers and administrators need policy to back them up.
- ☆ *Awareness and understanding:* The policy adoption process can increase people's knowledge about the facts, the complexity of issues, and the laws that shape schools' actions.
- ☆ *Accountability*: Policies typically state *who* is responsible for doing *what*.
- ☆ *Legal protection:* Sound policy helps to prevent abuses that are grounds for legal action. Their adoption demonstrates good faith effort, which also helps protect the school system from damaging and expensive lawsuits.

The way an education agency develops, adopts, and implements a policy is critically important. A policy's quality and usefulness largely depends on who drafts it and supports it. The expertise of public health and legal specialists is essential. Staff members, parents, and students affected by a policy also need to actively participate in its development or review. Policymakers can lay a good foundation for public support by involving people from a variety of community groups in the process.

It takes time to conduct an inclusive policy process that considers many viewpoints. Disputes can arise. Yet the amount of time and energy used to develop broad support are worthwhile investments. Pages 4–5 suggest a step-by-step policy development process.

Policymakers should involve other agencies in the community to improve the coordination of different efforts and increase consistency among prevention messages. These might include youth-oriented

> Policies are most valuable if adopted *before* they are needed.
>
> Now is the best time to write or review them.

organizations such as 4–H or Boys and Girls Clubs, community-based organizations that serve people with HIV infection, agencies that serve youth in high-risk situations, the American Red Cross, social services agencies, or churches. Perhaps other schools or districts in the region might be willing to collaborate in a joint policymaking effort.

Developing and adopting sound policies are only the first steps. Implementing them requires widespread communication to obtain the buy-in and support of school staff members, family members, and the general public. Chapter III addresses engaging the community.

A word of caution:

"If a legal challenge is ever mounted to a school district's actions regarding [HIV] infection it will be based upon knowledgeable medical evidence, not upon the pooling of opinions.... A medically unsound policy will not be upheld in court regardless of how fervently it is believed and supported, how large and highly diversified the development committee, or how democratic the process."

Douglas Bates, Ph.D., J.D.
Utah School Law and Legislation Coordinator

At what level does policy belong?

Education governance models vary considerably across the United States. Whether a given policy is most appropriate at the state, school district, or individual school level depends on the context. For example, some states use centralized curriculum frameworks whereas others provide only general guidelines for local curriculum decisions. In some places the school district superintendent is the key decision maker, in other places the school principal, and in yet others specialized staff members have authority to handle certain matters.

Regardless of the context, experience proves time and again that policies must be "homegrown" to be effective. Policies need to reflect the unique characteristics and circumstances of states, districts, and communities. Users of this guide will undoubtedly have to adapt the recommendations to fit their own legal and education governance frameworks.

State policy levers

States can use several tools to promote HIV-related policies:

- Education goals and standards
- Curriculum frameworks
- School accreditation standards
- Required courses and graduation units
- Approved textbook lists
- Staff preparation and in-service development requirements
- Certification of teachers, administrators, and others
- Policies on specific issues, such as harassment
- Tests and other assessments
- Resolutions and position statements
- Training and technical assistance from the state education agency
- Policy samples, guidelines, and other information
- Public awareness campaigns

Should policies be specific to HIV?

When a subject causes intense concern it is usually best that policymakers directly respond to people's anxieties, even though there is no public health reason to address HIV infection apart from other health problems. In addition, parents and staff members might be more likely to pay attention to—and therefore use—a policy that specifically mentions HIV infection.

At the same time, policymakers should explicitly place an HIV infection policy within the context of a complete, coordinated school health program. For example, issues raised by

HIV infection can be imbedded into general policies for health, safety, attendance, special education, etc., as those policies are periodically updated. This encourages a broader perspective and places HIV infection into context with other illnesses, disabilities, and chronic conditions that are much more common.

Resources:

- ☆ Staff members at the National Association of State Boards of Education can give assistance on a broad range of state policy issues: contact (703) 684-4000 or healthy@nasbe.org. For assistance in developing policy see the chapter entitled "The Art of Policymaking" in *Fit, Healthy, and Ready to Learn: A School Health Policy Guide* or the guide for non-educators entitled *How Schools Work and How To Work With Schools*, available at (800) 220-5183 or go to www.nasbe.org/catalog.html.
- ☆ The National School Boards Association (NSBA) offers a series of policy issue briefs on establishing school health programs and foundation policies. Staff provide consultation and technical assistance to school districts on HIV-related policies and programs, and they maintain an HIV/AIDS Resource Database that includes sample school district policies. Call (703) 838-6722 or go to www.nasba.org/schoolhealth.
- ☆ The Division of Adolescent and School Health (DASH) of the Centers for Disease Control and Prevention (CDC) offers useful resources including school health guidelines, guidance on specific curriculum "Programs That Work," and a school health finance database that contains regularly updated information on federal, state, and private sector funding sources. Requests for resources or technical assistance should be sent to HealthyYouth@cdc.gov or call (888) 231-6405.
- ☆ DASH also offers a *Handbook for Evaluating HIV Education* that contains a section on policy development, including checklists for policy process and policy content. Go to www.cdc.gov/nccdphp/dash/evaluation_manuals/hiv.htm.
- ☆ The Education Law Association offers a comprehensive guide, *The Formulation of AIDS Policies: Legal Considerations for Schools*. View the abstract and submit an order at www.educationlaw.org/publications/aids.htm or call (937) 229-3589.
- ☆ The National PTA maintains an HIV/AIDS and Comprehensive School Health Programs Resource Library at www.pta.org/programs/hivlibr.htm. Among their resources is the *HIV/AIDS Education Planning Guide for PTA Leaders*. Call (800) 307-4782.

NATIONAL PTA: Schools need policies

"School boards should adopt policies concerning students and staff infected with HIV, and state, region, district, council, and local PTAs should become and remain involved in developing such policies…

"Since no known cases of AIDS have been attributed to casual contact in the school, day care, foster care, home or work setting, National PTA discourages all actions that would seek to segregate, persecute or ban from school, children or staff with HIV infection, or that would force the inappropriate disclosure of information that could identify persons infected with HIV. Decisions concerning school placement of HIV-infected children should be made jointly by the child's parents or guardians, physician, school superintendent, and public health official."

Revised 1997

Developing school policies concerning HIV infection

Step 1: Clarify the need for a new or revised policy concerning HIV infection. Gather ideas from school staff members and the policy recommendations contained in Chapter II. Review existing policies on health, safety, students with disabilities, employees with chronic diseases, confidentiality, and health education.

Write a brief description of the issues that need to be addressed.

Step 2: Critically assess the existing policy development *process*. Before working on HIV-related policies it might be necessary to revisit the "foundation policies" that express an educational vision and define policymaking participants, protocols, timelines, and how to involve the public. For example, rules governing the conduct of speakers at hearings and meetings can help to defuse controversy—but only if adopted before the need arises.

Step 3: Use established procedures to bring the policy needs to the attention of the decision making body (e.g., the school board).

Be prepared to suggest who should work to draft or revise a policy. A School Health or Safety Advisory Committee is a natural forum for considering HIV-related policy ideas. Its backing can help begin to build a broad base of community understanding and support. If such a committee does not exist, an appointed special task force can draft policies.

To the extent possible, a policy drafting body should include:

- ☆ Parents, guardians, and/or family members of students.
- ☆ Teachers and administrators.
- ☆ School health staff, pupil services personnel, building maintenance workers, food workers, bus drivers, and/or others.
- ☆ Middle and high school students, both because the policies directly affect them and they provide a valuable "reality check."
- ☆ Medical advisors knowledgeable about child development and school health issues.
- ☆ Attorneys familiar with federal, state, tribal, and/or local laws as they impact schools.
- ☆ People living with HIV infection because their experiences are informative.
- ☆ A broad range of community representatives with diverse perspectives, such as clergy, racial and ethnic group leaders, and members of influential organizations. The process can build bridges of respect among those with dissimilar viewpoints and constituencies. Participation in the give-and-take discussions increases their understanding of the many factors policymakers must balance.
- ☆ Public health and social services agencies, youth serving organizations, AIDS services organizations, and other community-based organizations, to enhance cross-agency coordination. Consider including those who work with youth who are at highest risk for HIV infection, such as injectable drug users, runaway and homeless youth, or gay youth.

- ☆ A collective bargaining agreement might require that a teachers' association or school employee union representative be included in the process.

Identify a staff professional who could provide research and writing support to the policy drafting committee.

Draft for the school board's consideration a clear written mandate for the committee, with a specific action timeline.

Step 4: Assemble information on federal, state, and tribal laws and regulations; sample policies; and information on the most current scientific and medical findings about HIV infection. Call on colleagues, local community experts, and state and national agencies and organizations for assistance.

Step 5: Conduct study sessions for both the committee and the school board on the facts and their major policy options. It is critical that everyone clearly understands the legal parameters. Arrange for short presentations by credible experts, with ample opportunities for members to pose questions and express their concerns and perspectives. Open meeting laws might require that these sessions be public.

Step 6: Draft policy language, drawing on the information gathered and the values and experiences of committee members. Following are some guiding principles:

- ☆ Use clear language and accurate terminology (see Appendix D), avoiding education, medical, and legal jargon to the extent possible.
- ☆ The policy should provide practical guidance to school staff members on how to address specific issues.
- ☆ Be consistent with state, district, and school visions for student learning, education reform efforts, and other current initiatives.
- ☆ Review the draft language again and again for consistency with federal, state, tribal, and local laws and regulations.
- ☆ Build in accountability—cite who will be held responsible for doing what.
- ☆ Include provisions for policy evaluation and periodic review.

Step 7: Allow time for committee members to share draft policies with their constituencies, gather opinions, and report back to the full committee.

Step 8: Prepare the final draft for presentation to the school board.

Begin to develop a proactive communications plan to explain the issues and build support among staff members and the public (Chapter III). Also prepare a controversy management plan, just in case.

Step 9: Provide requested support as the decision making body commences the policy adoption process according to its established procedures.

Step 10: Once adopted, implement the communications plan to inform and educate the community about the policy. Prepare fact sheets, talking points, and other written materials. Translate the policies into other languages as needed so that staff members, the public, and students can easily understand them. Schedule and conduct information sessions for the media and parent groups.

Step 11: Implement the policies.

Chapter II: POLICY RECOMMENDATIONS

A preamble and nine parts of a complete HIV infection policy are presented in the following pages. Each section includes sample policy language, an explanation justifying the policy, the legal context, implementation guidance, excerpts of actual state and local policies, and selected resources.

☆ ☆ ☆

Preamble

SAMPLE POLICY:

> *State/ District/ School* shall strive to protect the safety and health of children and youth in our care, as well as their families, our employees, and the general public. Staff members shall cooperate with public health authorities to promote these goals.
>
> The evidence is overwhelming that the risk of transmitting human immunodeficiency virus (HIV) is extremely low in school settings when current guidelines are followed. The presence of people living with HIV infection or diagnosed with acquired immunodeficiency syndrome (AIDS) poses no significant risk to others in school, day care, or school athletic settings.

EXPLANATION:

To date, there has been no known case of HIV transmission in a school, day care center, or school athletic setting. The evidence is strong that the risk of HIV infection is remote.

In the United States, doctors report every person diagnosed with AIDS to the Centers for Disease Control and Prevention (CDC). They also report each person's probable cause of infection. CDC investigates every case that appears to lack a known risk factor. With more than 500,000 cases reported, researchers consistently find that infection occurs through:

1) Engaging in vaginal, anal, or oral intercourse without adequate protection.

2) Sharing a needle or other skin-piercing instrument.

3) Acquiring the virus in the womb, at the time of birth, or during breast feeding.

4) Receiving contaminated blood or blood clotting factors before 1985. (Since then, every person wanting to donate blood is screened for personal risk behaviors, all donated blood is tested for HIV antibodies, and any blood found to contain HIV is destroyed. The risk of infection from a blood transfusion in the United States is now very low, estimated in 1992 at about 1 in 225,000.[4])

> Donating (giving) blood is perfectly safe—and always has been in the United States—because a new sterile needle is used with each and every person.

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Each of these routes allows HIV to directly invade a person's body. None is likely to happen at school. Epidemiologists, those who track and study epidemics, concluded long ago that transmission of HIV at school is highly improbable. Experience confirms this judgment.

*How HIV is **not** transmitted*

HIV cannot survive away from a person's body fluids unless kept in controlled laboratory conditions. It does not replicate in food, water, air, or insects.[5] It is not transmitted by contact with environmental surfaces.

Everyday casual contact with a person with HIV infection carries no risk. In seventeen research studies, not a single case of nonsexual HIV transmission occurred among 1,167 carefully monitored people living with a person with HIV infection.[6] The caregivers and other household members, including more than 300 children, generally shared kitchen, laundry, and bathroom facilities, meals, eating utensils, and drinking cups and glasses.

Sweat does not contain HIV, nor is it expelled in a cough or sneeze. Minute quantities of virus particles are sometimes detected in tears or saliva, but contact with these fluids has not been shown to result in HIV transmission. According to CDC, urine, feces, nasal secretions, or vomit do not present a risk of transmitting HIV unless blood is visibly present.

Many people worry about children who bite. The risk of HIV transmission is considered remote because the concentration of HIV in saliva is low when it is even detected at all, and bites rarely result in blood-to-blood contact. (Regardless, repeated biting or other wound-causing behaviors are serious discipline problems at school that call for intervention.)

*HIV cannot be transmitted through casual contact., which means it is **not** risky to...*

- shake or hold hands
- hug
- kiss
- share toys
- share offices, classrooms, or locker rooms
- share kitchens, bathrooms, or laundry rooms
- use public drinking fountains, toilet seats and doorknobs.
- swim in public pools
- eat food prepared or served by a person with HIV infection

INDIANA:
No evidence

There is no evidence to support that HIV can be transmitted by any type of so-called 'casual contact,' including all of the kinds of activities and behaviors that occur in school.

Indiana State Board of Health, 1988

HIV infection in household settings

There have been eight confirmed cases to date of non-sexual HIV transmission in household settings. Investigators eventually determined that direct contact with blood was the likely cause of infection in each case.

For example, one case concerned a toddler infected with HIV who passed the virus to another toddler. Investigators concluded that there were numerous opportunities for HIV to be transmitted through blood exposure. The first toddler had frequent nosebleeds and almost daily gum bleeding, and once bled heavily from a cut. The second toddler had an itchy skin rash, often with open sores. The two slept in the same bed.

None of the eight cases provided any new information about possible transmission routes. Year by year the evidence builds that all the possible transmission routes are known.

CDC emphasizes the need for every school and child care center to consistently follow current infection control guidelines. They do not recommend any changes in the guidelines on the basis of these rare cases.

RESOURCES:

Information about HIV and AIDS:

- ☆ Appendix B lists state HIV/AIDS information hotlines. Appendix C provides more detailed information about HIV transmission.
- ☆ The CDC National STD and AIDS Hotline operates 24 hours per day. Call (800) 342-AIDS for assistance in English, (800) 344-SIDA for Spanish, (800) 243-7889 TTY, or go to www.ashastd.org.
- ☆ The CDC National Prevention Information Network is the U.S. Government's primary reference, referral, and distribution service for information on HIV/AIDS, STDs, and TB. Many publications and databases are available online at www.cdcnpin.org. Or, call (800) 458-5231 for personal assistance, (800) 243-7012 TTY, e-mail to info@cdcnpin.org, or use the fax-on-demand service at (800) 458-5231.
- ☆ CDC's Division of HIV/AIDS provides the latest statistics on the epidemic with updates on research, treatment, testing, prevention, training, and conferences. Go to www.cdc.gov/hiv/dhap.htm.
- ☆ HIV InSite, a project of the University of California at San Francisco's AIDS Research Institute, is designed as a gateway to in-depth information and a fair and balanced representation of viewpoints on many controversial aspects of AIDS. All materials posted to the site at http://hivinsite.ucsf.edu are reviewed for credibility, reliability and accuracy.
- ☆ The American Red Cross offers an *HIV/AIDS Fact Book* that provides basic information in a question-and-answer format suitable for laypersons and health professionals. It is available in English and Spanish from your state or local chapter, which can be located through www.redcross.org.
- ☆ The HIV/AIDS Resource Center of the Journal of the American Medical Association (JAMA) contains a variety of special reports, credible scientific research findings, and "Best of the Net" sites selected by JAMA's editorial review and community advisory panels. Go to www.ama-assn.org/special/hiv/hivhome.htm.

Continued

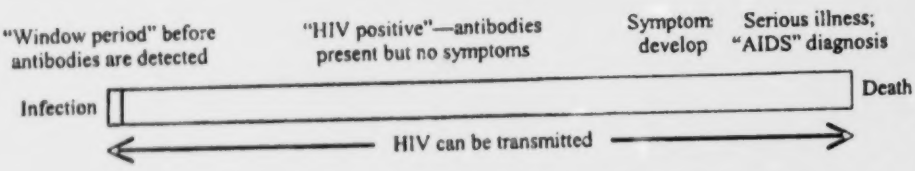
What is HIV and what is AIDS?

The terms AIDS and HIV are often confused. For clarity of discussion and the development of good policy, it is important to understand the difference.

HIV, the Human Immunodeficiency Virus, is a pathogen that can be transmitted from one person to another in certain specific ways. A person can live with HIV infection for many years without experiencing symptoms of illness.

AIDS, or Acquired Immuno-Deficiency Syndrome, is the advanced stage of HIV infection and a life-threatening medical condition. CDC defines the point at which HIV infection becomes a diagnosis of AIDS. Without medication, symptoms of AIDS appear in an adult an average of ten years after infection with HIV and most adults die within two years of an AIDS diagnosis. Disease often progresses more rapidly in infants and children.

Stages of HIV infection



The length of time at each stage varies considerably from person to person

☆ ÆGIS is a nonprofit charitable and educational corporation whose website contains a vast amount of continually updated information with links to news services, law libraries, and activist organizations. Go to www.aegis.com.

☆ The Body: An AIDS and HIV Information Resource is designed to lower barriers between patients and clinicians by providing a public space in which such organizations and experts can exchange information and ideas. Go to www.thebody.com.

☆ UNAIDS, the Joint United Nations Programme on HIV/AIDS, has a global mission to lead, strengthen, and support an expanded response to the epidemic. The UNAIDS Information Centre in Switzerland has published materials on a variety of topics, many of which are online at www.unaids.org. To obtain a catalog, e-mail to unaids@unaids.org.

Policy guidance:

☆ Your state department of education might be able to provide policymaking advice and sample policies. For example, Vermont offers a sample policy at www.state.vt.us/educ/HIVpol.doc.

☆ *Supports for Children with HIV Infection in School,* a supplement to the January 1994 issue of the *Journal of School Health* (vol. 64, no. 1), includes six informative background papers, two surveys, and best practices guidelines in English and Spanish. Also available is a topical package of dozens of articles from the *Journal of School Health* that address HIV. Call (330) 678-1601 or go to www.ashaweb.org.

☆ The American Academy of Pediatrics has a number of relevant policy statements online at www.aap.org/policy/pprgtoc.cfm. AAP also offers *Pediatric Human Immunodeficiency Virus (HIV) Infection* a compendium of policies plus additional guidelines from the US Public Health Service, Infectious Diseases Society of America, and CDC. Call (888) 227-1770 or go to their online bookstore at www.aap.org.

☆ The American Public Health Association (APHA) and the American Academy of Pediatrics (AAP) jointly produced a detailed policy guide, *Caring for Our Children—National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. Call (301) 893-1894 or go to www.apha.org/media/abc1.htm.

The organizations included as resources in this guide all offer a broad range of assistance, make referrals, have a national scope, are easily accessed, are available at low or no cost, or have specialized expertise. Contact information for each organization can be found in Appendix A.

These resource lists are not exhaustive. Scores of other organizations provide high quality assistance and advice to educators and hundreds of informative books and articles are available. Many of the Internet sites contain extensive links to additional resources.

The organizations are included here for informational purposes only. NASBE does not necessarily endorse each organization's public policy views or positions.

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Section 1. School Attendance

SAMPLE POLICY:

> A student with HIV infection has the same right to attend school and receive services as any other student, and will be subject to the same rules and policies. HIV infection shall not factor into decisions concerning class assignments, privileges, or participation in any school-sponsored activity.
>
> School authorities will determine the educational placement of a student known to be infected with HIV on a case-by-case basis by following established policies and procedures for students with chronic health problems or students with disabilities. Decision makers must consult with the student's physician and parent or guardian; respect the student's and family's privacy rights; and reassess the placement if there is a change in the student's need for accommodations or services.
>
> School staff members will always strive to maintain a respectful school climate and not allow physical or verbal harassment of any individual or group by another individual or group. This includes taunts directed against a person living with HIV infection, a person perceived as having HIV infection, or a person associated with someone with HIV infection.

EXPLANATION:

As the risk of HIV transmission at school is minimal, there is no reason to exclude or put conditions on the attendance of a student who has HIV infection. No special safety precautions are required to protect others. School officials should assign the student to his or her regular classroom, unless the student's particular needs demand otherwise.

Communicable disease policies designed to prevent the spread of contagious infections that are transmissible at school should still apply to a student with HIV infection. For example, if such a student also has the measles, school officials can justify a temporary suspension until the student is no longer contagious with measles. A bloody or oozing skin sore that cannot be covered is another reason to keep a student—*any* student—away from school until the condition clears up.

It is not necessary to automatically invoke a dedicated decision making process to consider every case of HIV infection. School authorities should use their established procedures for accommodating students with disabilities or chronic health problems, if and when a student with HIV infection has special needs. There is nothing unique about HIV infection that these procedures could not address.

Schools must not tolerate hostility, ridicule, shaming, or rejection shown towards a person living with HIV infection. HIV itself poses less of

A sound communicable disease policy:

- ☆ Makes a clear distinction between infections known to be contagious in school and athletic settings, such as chicken pox, flu, or ear infections; and infections not shown to be transmissible at school, such as HIV.
- ☆ Details a medically oriented decision making process that is:
  - ✓ timely and fair,
  - ✓ relies on expert advice,
  - ✓ requires credible evidence of the possibility of infection,
  - ✓ conforms to public health recommendations,
  - ✓ seeks the consent of the student (or parent/guardian) for actions taken, and
  - ✓ allows appeals.

a threat to the well-being of a school community than such abuse; harassment can ruin an entire school's learning climate.

THE LEGAL CONTEXT:

Civil rights: A policy of permitting full school attendance and equitable treatment of a student with HIV infection is safe, humane, and good for the social growth of *all* students. It is also legally required.

Federal civil rights laws, particularly Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA), protect the rights of people with disabilities and prohibit discrimination. The U.S. Congress has defined HIV infection, with or without symptoms, as a disability. These laws also protect uninfected people who are treated as if they have HIV infection, and those who associate with people with HIV infection. Courts consistently uphold these protections.

The Section 504 regulations mandate that every student with a disability be provided a "free, appropriate public education." The ADA extends Section 504's anti-discrimination provisions to private non-religious schools. Together these laws allow families legal recourse if a student's education is denied or altered for no other reason than HIV infection.

Placement decisions: Under Section 504 and the ADA, a student has the right to remain in the regular educational environment—with the assistance of supplementary aids, services, or some other accommodation if needed—unless it is demonstrated that the student cannot be educated there. School authorities must conduct an individualized planning process if they determine that a student with a disability needs an accommodation. Documented proof of the process is necessary,

GEORGIA:
Policy definition

Communicable disease: a disease that can be directly (i.e., through casual contact) or indirectly (i.e., through the air or inanimate objects) transmitted from one person to another. For purposes of this policy, the term "communicable disease" does NOT include HIV disease...

1990

Federal laws and the Supreme Court consider HIV infection and AIDS to be disabling conditions.

HAWAII:
Do not exclude

HIV-infected students do not pose a transmission risk to others in the school setting and therefore should not be excluded from the school setting based on their HIV status.

1994

MONTANA: Model communicable disease policy

The _____ Public School District will work cooperatively with the _____ County Health Department to enforce and adhere to this policy for the prevention, control, and containment of communicable diseases in schools...

B. The Superintendent has the authority to exclude a student or staff member from school when reliable evidence of information from a qualified source confirms him/her of having a communicable disease or infection that is known to be spread by any form of casual contact[1] .and is considered a health threat to the school population. Such a student or staff member shall be excluded unless their physician approves school attendance or the condition is no longer considered contagious. All reportable communicable diseases will be referred to the _____ County Health Department...

[1] [A study in the *New England Journal of Medicine* concludes that] long-term household exposure... to a person with HIV infection and AIDS poses minimal or no risk of transmitting HIV.

February 1990

VIRGINIA:
Regular classroom assignment

Since it is known that HIV is not transmitted through casual contact, any student who is HIV infected will continue education in a regular classroom assignment unless the health status interferes significantly with performance. If a change in the student's program is necessary, the Superintendent or designee, family, and physician or health official will develop an individual plan which is medically, legally, and educationally sound.

1989

NEA: Placement of students with HIV/AIDS

"The National Education Association supports establishing local policy that ensures a free, appropriate public education in a least-restrictive environment for all students infected with HIV or with AIDS.

"The Association believes that the placement of such students in school is a medical decision that should be made on a case-by-case basis by qualified health care professionals.

"The Association further believes that student should not be refused admittance to school or subjected to any other adverse action solely because they have tested positive for HIV or have been diagnosed as having AIDS.

"The National Education Association opposed mandatory/involuntary HIV/AIDS testing of students."

1993

which could be an individualized education program (IEP), an individualized health plan (IHP), or evidence of another planning process that conforms to Section 504 regulations concerning student identification, evaluation, and placement.

Special educational services: Section 504 and the ADA are civil rights protection laws: they do not obligate the federal government to help pay for a student's free, appropriate public education. In contrast, the Individuals with Disabilities Education Act (IDEA) is a federal funding program that helps school districts educate students who have disabilities. IDEA has specific criteria that determine who is eligible for services. A student is eligible who has a disability specifically listed in the law or who has "limited strength, vitality or alertness, due to chronic or acute health problems...that adversely affect a child's educational performance." IDEA outlines procedures for student identification, evaluation, and placement that are more specific than the Section 504 requirements.

Harassment: Under the terms of the federal Civil Rights Act of 1991, which also prohibits discrimination on the basis of a disability, a school could be held liable for monetary damages if school authorities are aware of harassment aimed at a person with HIV infection and do not intervene to stop it or prevent it from continuing to occur.

Appendix E describes in more detail how Section 504, the ADA, and IDEA apply to schools. Prudent administrators will ensure that their policies and procedures conform to state and tribal laws and these federal laws and regulations.

Children with AIDS now average 1.4 hospitalizations per year compared with 2.3 to 5 per year in the mid-1980's. Over half of the children in a recent study reported no inpatient admissions at all over an 18-month study period.[7]

IMPLEMENTATION:

The symptoms and progress of HIV infection differ with each person. Students with HIV infection might, or might not, need the kinds of educational services provided for others with disabilities or chronic health conditions.

One student with HIV infection might have no special health or educational needs at all, while another experiences chronic fatigue, and a third is occasionally hospitalized. Temporary accommodations could involve modifying schedules, course loads, or grading policies; administering medications or basic health care procedures; or other adjustments as schools routinely allow for students with chronic health conditions such as asthma or diabetes. A student's physician might advise periods of home tutoring because some people with HIV infection are particularly susceptible to minor infections commonly passed in classrooms, such as measles or chicken pox.

Other children with HIV infection might require intensive, specialized attention to overcome significant learning barriers. HIV infection and its associated complications can delay development and cause memory, cognitive, or sensory impairments.

A student who does not actually have HIV infection but has been orphaned, has parents or other family members with the infection, or is from a seriously disrupted family, might also need special educational services. This student, too, is "living with HIV" and could have serious emotional, social, or behavioral problems that interfere with learning.

Deciding when the regular school program no longer serves a student with a health impairment or disability can be a challenge for administrators. There are no hard-and-fast rules: initiating an evaluation process is a professional judgment call that should be made in consultation with the student's teachers; the school nurse; the student's physician; and parents, guardians, or other caregivers. The principle to remember is: focus on the child, not the virus.

DENVER: Student placement

Decisions about the proper educational placement of a student with HIV infection shall be based on, among other things, the student's neurologic development, physical condition, and behavior. A regular evaluation of the placement decision shall be conducted to assess changes in the student's physical condition.

In the event a student with HIV infection qualifies for services as a child with disabilities under state and federal law, the procedures for determining the appropriate educational placement in the least restrictive environment shall be used...

In the development of an individualized education program (IEP), school personnel should consider expanding the staffing committee to include the student's physician and a public health official to serve in an advisory capacity.

1994

Individualized Health Plan

In many schools, a nurse prepares an individualized health plan (IHP) for a pupil with a chronic health condition such as cancer or diabetes. In some states an IHP can be used for Medicaid reimbursement.

Whatever procedural model is used to prepare a plan of support, school authorities should be able to cope with urgent situations, and, if a student's condition improves, to promptly alter or suspend services. A student should remain in his or her regular classroom while an evaluation and planning process is proceeding.

The people who together develop a plan of support should include, at a minimum:

- ☆ The student's teacher and other relevant personnel, such as a specialist in educating students with disabilities, the school nurse, or the school psychologist.
- ☆ Parents or legal guardians, or other family caregivers, because they are the experts on a child's daily condition and know what is "normal" for that child (they might need methodical explanations or translation services to fully participate).

"The perception of AIDS...is changing. Previously considered fatal in the short term...AIDS is now viewed increasingly as a long term disease...in which therapy might significantly prolong life and some complications might be totally preventable."

Journal of the American Medical Association

Suggestion

School officials don't always know who might have a deficient immune system. Instead of alerting only certain families about a contagious infection spreading at school, many schools have on hand, and promptly send home with every student, pre-written "contagious illness alerts."

- ☆ The student's physician or another medical professional who is knowledgeable about pediatric HIV infection.
- ☆ The student, who should be involved to the extent that his or her degree of maturity and understanding allows.

A family's request to keep HIV infection confidential has to be respected. Disclosure to everyone on the planning team is not necessary. The virus is not relevant: the student's physical condition and learning impairments are.

Sometimes it is difficult to apply federal laws' requirements to specific students. With mutual respect, trust, compassion—and time—it should be possible to reach consensus on the best course of action. An attorney might need to be consulted; this can be done without disclosing names.

Are students with HIV infection always eligible for special education services?

A full evaluation under either Section 504 or IDEA is not required if neither school officials nor a student's parents believe the student needs accommodations or services. In fact, a school system can be accused of discrimination in violation of Section 504 if every student with HIV infection is automatically referred for special educational services. The key is that each student's unique educational needs, health condition, and individual circumstances be considered on a case-by-case basis.

Students should **not** be referred for special education services simply because of HIV infection.

What if staff members fear a student with HIV infection?

Fear is a common first reaction to HIV. Getting beyond it typically requires an accurate understanding of the facts, plus time to become accustomed to the situation. Every staff member should be able to participate in informational workshops that address personal concerns and allow for plenty of questions (see Section 8). A credible, strictly enforced infection control policy can also reduce staff anxiety (Section 4).

Administrators should expect staff members to put aside any personal biases about HIV, and to model attitudes of compassion and tolerance. If resistance is serious or continuing, it might be necessary to remind the staff about performance-of-duty policies.

How can a school prevent harassment

Hostility towards people with HIV infection typically arises from ignorance or a misconception, such that it is risky to touch a person with the infection, or that AIDS is an

immediate death sentence, or that HIV infection implies certain sexual activities or sexual orientation. All of these assumptions are wrong. Effectively preventing harassment must therefore begin with correcting misguided ideas that are based on inaccurate or incomplete information.

Effective curricula addressing conflict prevention, control, and resolution are now available. A serious harassment problem justifies implementing one of these programs.

National Education Goal Seven

Every school in America will be free of... violence... and offer a disciplined environment conducive to learning.

1995

RESOURCES:

Civil rights:

- ☆ Federal law requires every school district to have a Section 504 compliance officer who should be up to date on applicable laws.
- ☆ The Office for Civil Rights (OCR) of the U.S. Education Department at www.ed.gov/ocr offers additional information about legal protections and guidance on developing nondiscrimination policies. To file a complaint or to obtain technical assistance on a problem, contact a regional enforcement office whose number can be obtained from the above website. For assistance from OCR call (800) 421-3481 voice, (877) 521-2172 TDD, or e-mail to OCR@ed.gov.
- ☆ The U.S. Department of Education supports a network of Disability Business Technical Assistance Centers to promote the understanding and knowledge of the Americans with Disabilities Act (ADA) and provide assistance, training, materials, and referrals. The network can be reached at (800) 949-4232 (voice/TTY) or go to www.adata.org.
- ☆ The U.S. Department of Justice provides information about the Americans with Disabilities Act through a toll-free ADA Information Line. For general information, answers to specific technical questions, free ADA materials, or information about filing a complaint, call (800) 514-0301 (voice) or (800) 514-0383 (TDD). Spanish language service is also available.
- ☆ The Center for Law and Education supports the rights of students with disabilities through litigation, by providing training and technical assistance to attorneys representing students and parents, and by publishing materials concerning the legal rights of students with disabilities. Call (202) 986-3000, e-mail to cle@cleweb.org, or go to www.cleweb.org.

Education for students with disabilities:

- ☆ *Winners All: A Call for Inclusive Schools* from the National Association of State Boards of Education contains advice on developing state-level special education programs and policies. Call (800) 220-5183 or go to www.nasbe.org/catalog.html.
- ☆ The U.S. Education Department's Office of Special Education Programs has detailed information and resources on the Individuals with Disabilities Education Act at www.ed.gov/offices/OSERS/OSEP/index.html.
- ☆ Parent Training and Information Centers and Community Parent Resource Centers in each state provide training and information to parents of infants, toddlers, school-aged children, and young adults with disabilities and the professionals who work with their families. To reach the parent center in your state, contact the Technical Assistance Alliance for Parent Centers at (888) 248-0822 voice, (952) 838-0190 TTY, e-mail to alliance@taalliance.org, or go to www.taalliance.org.
- ☆ The Federal Resource Center for Special Education supports a nationwide technical assistance network to respond to the needs of students with disabilities, especially students from under-represented populations. Call (202) 884-8215 voice, (202) 884-8200 TTY, or e-mail to frc@aed.org.
- ☆ The National Information Center for Children and Youth with Disabilities makes available a variety of publications including fact sheets, state resource sheets, parent guides, bibliographies, and issue papers. Most publications can be printed off the Internet, or they can be requested in print or in alternative formats. Information specialists are available to provide assistance at (800) 695-0285 voice or e-mail nichcy@aed.org.

Continued

☆ The ERIC Clearinghouse on Disabilities and Gifted Education gathers and disseminates professional literature, information, and resources on the education and development of individuals of all ages who have disabilities and/or who are gifted. Call (800) 328-0272 (voice/TTY) or e-mail to ericec@cec.sped.org.

Support services:

☆ Contact an HIV/AIDS services organization in your area to learn about local assistance available for people with HIV infection. Many are linked with the National Association for People with AIDS at www.napwa.org/resource.htm, with the CDC National Prevention Information Network at www.cdcnpin.org/rellinks.htm, and/or with The Body at www.thebody.com/hotlines/other.html.

☆ The American School Health Association offers several publications with guidance on HIV infection and the school setting, including *Managing the School-Age Child with a Chronic Health Condition*. Call (216) 678-1601 or go to www.ashaweb.org.

☆ The American Academy of Pediatrics has a detailed policy on *Education of Children With Human Immunodeficiency Virus Infection* at www.aap.org/policy/re9950.html.

☆ Many professional membership organizations offer specialized technical assistance and guidance on providing services to students who are living with HIV infection. Pupil services and special education personnel can call:

American School Counselors Association at (800) 306-4722 or www.schoolcounselor.org;

Council for Exceptional Children at (888) CEC-SPED or www.cec.sped.org;

National Association of School Nurses at (207) 883-2117 or www.nasn.org;

National Association of School Psychologists at (301) 657-0270 or www.naspweb.org;

National Association of Social Workers at (800) 638-8799 or www.naswdc.org.

☆ *Guidelines on Developmental Services for Children and Adults with HIV Infection* is available from the American Association of University Affiliated Programs for Persons with Developmental Disabilities at (301) 588-8252 or e-mail to info@aauap.org.

☆ The Social Security Administration operates a confidential benefits information hotline at (800) 772-1213 or (800) 325-0778 TTY. A publication entitled *Social Security Benefits For Children With Disabilities*, written for the parents and caregivers, illustrates the kinds of Social Security and Supplemental Security Income (SSI) benefits a child with a disability including HIV infection or AIDS might be eligible for, and explains how disability claims for children are evaluated. Go to www.ssa.gov/pubs/10026.htm.

☆ The Council of School Attorneys of the National School Boards Association can provide detailed advice concerning do-not-resuscitate orders and other legal issues. Call (703) 838-6722.

☆ The AIDS Alliance for Children, Youth and Families provides information, resources and support to consumers and providers of HIV/AIDS services. Go to www.aids-alliance.org or call (202) 785-3564.

Harassment:

☆ *Schools Without Fear* is available from the National Association of State Boards of Education at (800) 220-5183 or go to www.nasbe.org/catalog.html.

☆ *Protecting Students from Harassment and Hate Crime: A Guide for Schools* that includes sample school policies is available from the U.S. Department of Education on-line at www.ed.gov/pubs/Harassment/index.htm. For additional resources visit the Safe & Drug-Free Schools Program website at www.ed.gov/offices/OESE/SDFS, or call (877) 4-ED-PUBS or (877) 576-7734 TTY/TDD.

☆ The Gay, Lesbian, and Straight Education Network (GLSEN) offers a variety of resources concerning safe schools, law and policy, staff development, and school curricula. Go to www.glsen.org or call (212) 727-0135.

☆ ☆ ☆

Section 2. Employment

SAMPLE POLICY:

> The *State/District/School* does not discriminate on the basis of HIV infection or association with another person with HIV infection. In accordance with the Americans with Disabilities Act of 1990, an employee with HIV infection is welcome to continue working as long as he or she is able to perform the essential functions of the position, with reasonable accommodation if necessary.

EXPLANATION:

An employee with HIV infection does not pose a risk of transmitting HIV to others in schools, locker rooms, offices, or other public places when current infection control guidelines are followed. There is no need to restrict a person's work in any way solely on the basis of the infection. Nevertheless, if an employee with HIV infection also has another infection or other condition that is known to present a risk of disease transmission at school, established personnel policies concerning the prevention of communicable diseases should still apply.

THE LEGAL CONTEXT:

Legal requirements regarding employees differ in important ways from those for students. School administrators must conform to:

- ☆ The Americans with Disabilities Act (ADA), which protects a person with a disability from discrimination in the workplace.
- ☆ Pertinent state, tribal, or local laws and regulations that address disability, discrimination, and confidentiality issues.
- ☆ Additional requirements and procedures arrived at through collective bargaining.

Discrimination: Title I of the ADA aims to prevent any kind of employment discrimination against a person with a disability. HIV infection and AIDS are specifically defined as disabilities in the legislation, and are consistently treated as such by the courts. This means that an employer cannot take action against an employee solely because of HIV infection or its related symptoms if the person is "otherwise qualified" for the job on the basis of skill, experience, or education. Nor can an employer fail to hire a job applicant who is living with HIV infection.

All decisions concerning work assignments, recruitment, hiring, promotions, training opportunities, transfers, suspensions, termination, life and medical insurance benefits, and all other terms of employment must ignore HIV status. If an employer releases a

> MISSOURI:
> Work without restrictions
>
> An employee infected with a bloodborne pathogen such as hepatitis B virus, hepatitis C virus, or HIV poses no risk of transmission through casual contact to other persons in a school setting. Employees infected with one of these viruses shall be allowed to continue work without any restrictions which are based solely on the infection.
>
> *1995*

person with HIV infection from employment for any reason, the employee must retain eligibility for the same benefits he or she would have otherwise received. Similarly, normal criteria and rules must apply if an employee chooses to retire on the basis of disability.

Those who actually have HIV infection are not the only ones protected from discrimination: the ADA also protects anyone *perceived* to be infected, *treated* as being infected, is *associated* with someone living with HIV infection, or *has a known relationship* with a person with HIV infection. It is also unlawful to intimidate or retaliate against a person filing a grievance or assisting someone else with a complaint.

Reasonable accommodation: The ADA requires an employer to allow an employee who is living with HIV infection to work if he or she is able to perform the fundamental elements of the job with "reasonable accommodation." An employer must provide, at no cost, a requested accommodation or an equally effective alternative unless the accommodation poses an "undue hardship" on the employer.

Reasonable modifications and adjustments to the usual work rules might include permitting periodic rest periods to be made up later, trimming the marginal aspects of the job (such as hall patrol duty), or being flexible about occasional absences due to hospitalization or a need to avoid a contagious illness at school. An employer might have to provide job-related aids or services, or change a person's work site. What matters is achieving the job's outcome, not how the job is performed.

Blindness or other sight impairments often accompany advanced HIV infection. An employer cannot dismiss someone for such a disability if accommodations allow the person to perform the job.

The ADA allows reassigning an employee to a vacant position that she or he is qualified for if no other solution is reasonably possible. For example, if a physician cautions a teacher with HIV infection to avoid acquiring measles, meaning the teacher should not have much contact with children, school officials should reassign him or her to a non-classroom job.

Schools and districts should be careful to document all actions concerning accommodations. Records ought to include the date an accommodation was requested or otherwise made known, offers made to the employee about providing an accommodation, and the employee's responses to the offers.

Testing for HIV: Under the ADA a supervisor cannot require an HIV antibody test, because the results do not provide information relevant to any school-related job. Nor can a supervisor inquire whether or not a staff member has HIV infection. If an employee voluntary discloses HIV infection, the employee must not be penalized for it in any way.

Suspension and termination: The ADA does permit suspending or terminating an employee who, even with accommodation, is permanently unable to perform the "essential functions" of his or her job. An employer's concerns must be based on the direct, job-related effects of serious illness, not based on HIV infection *per se*.

An employer can require a medical evaluation to determine an employee's fitness to work. (However, an employer cannot use the results of a voluntary medical examination against an employee, such as one organized within a school-site health promotion program.)

Administrators should not hesitate to prevent the spread of a disease known to be transmissible at school. A staff member with measles, for example, can be ordered to take

sick leave regardless of whether he or she has HIV infection. The ADA allows dismissing someone who poses a direct threat to the health or safety of others, but just the fact that someone has HIV infection is not such a threat.

Other points: The ADA applies to both the public and private sectors, to labor unions, and to institutions controlled by religions—*any* organization employing fifteen or more people. Its protections extend to employees who are not citizens.

The ADA does not require any job preference, or any special treatment in a performance evaluation. Administrators can still discipline a staff member with HIV infection, as long as he or she is treated the same as everyone else.

Employers must keep medical records of employees with disabilities confidential and separate from their personnel files.

According to the Job Accommodation Network, most accommodations made to conform to the ADA cost employers little or nothing.

IMPLEMENTATION:

A supervisor should do everything possible to expedite the application process if an employee with AIDS or advanced HIV infection chooses to retire on the basis of disability. AIDS is a life-threatening condition and illness can sometimes progress rapidly.

A collective bargaining agreement might have to be taken into account when dealing with a person's employment status—but the terms of the agreement cannot overrule what the ADA requires.

Tips for helping people with HIV infection

- ☆ Spend time listening and talking. *People with HIV and their families need to communicate their concerns about what is happening. Don't be afraid to discuss HIV infection. Encourage open expression.*
- ☆ Don't avoid negative feelings. *Negativity is a normal reaction to illness and should be dealt with, not ignored.*
- ☆ Include the person with HIV infection in activities; help the individual make realistic plans for the future. *Staying involved in family life can help a person with HIV infection fight the sense that his or her life is out of control.*
- ☆ Don't be afraid to touch or hug. *You cannot acquire HIV from ordinary physical contact. Holding a hand or giving a hug can provide a great deal of emotional support.*
- ☆ Offer to help find professional counseling or support groups. *If desired, help the person with HIV infection locate outside emotional supports. Offer to provide transportation, child care, or other services to ensure that appointments are kept.*

People infected with HIV do not develop AIDS immediately; they often remain healthy for a long period of time. Therefore, an individual living with HIV infection must concentrate on staying strong and healthy. Eating well, practicing good hygiene, avoiding exposure to disease, and exercising regularly under the direction of a doctor are necessary for good health. In addition, since mental well-being influences physical well-being, a positive attitude is an extremely important component to staying healthy.

American Association for World Health

Should there be mandatory testing for HIV?

No. It might seem a good idea to routinely test students and school staff members for HIV antibodies, but such a policy is ill-advised for a number of reasons:

- ☆ Policymakers cannot rely on negative results. Detectable antibodies take some time to develop (generally within a few weeks but occasionally as long as six months to a year). A person who tests negative could test positive, or become infected, a day after taking the test.
- ☆ The cost of mandatory HIV screening far outweighs the benefits. In 1987 Illinois required an HIV antibody test for all marriage license applicants. It cost an estimated $2.5 million to test 70,846 people within a six-month period, and only eight individuals with HIV infection were identified. The law was soon repealed.
- ☆ Every state protects the confidentiality of HIV test results.
- ☆ Federal laws that prohibit discrimination on the basis of disability or perceived disability prevent taking any action against persons found to have HIV infection.
- ☆ Public health experts assert that only a voluntary testing program can be effective.
- ☆ Most Americans object to government intrusion into their personal lives. Many at high risk of HIV infection would find ways to avoid being tested, especially if they do not believe they are at risk. The number of marriages in Illinois fell dramatically; many people traveled to neighboring states to be married.

Calls for mandatory testing can result from anxieties and misconceptions about HIV transmission. This might mean that some people do not understand that the chances of HIV being transmitted at school are extremely low, and could indicate a need for a community education initiative.

It is sometimes difficult to apply the ADA to specific cases. A school administrator might have to consult an attorney.

RESOURCES:

Workplace policies:

- ☆ CDC sponsors *Business Responds to AIDS* and *Labor Responds to AIDS*, programs working in partnership with businesses, labor unions, trade associations, public health departments, AIDS service organizations, and government agencies to promote the development of comprehensive workplace HIV/AIDS programs. Specialists answer questions, distribute materials, make referrals, and identify resources at (800) 458-5231 voice, (800) 243-7012 TTY, or e-mail to brta-lrta@cdcnpin.org. Managers' and Labor Leaders' Kits with resources needed to build comprehensive AIDS in the workplace programs, including guides to Social Security and SSI Disability Benefits, the Americans with Disabilities Act, and the Family Medical Leave Act, are online at www.brta-lrta.org.
- ☆ The Job Accommodation Network, a consulting service supported by the U.S. Department of Labor, offers an *ADA Evaluation Checklist and Guide* to help supervisors develop policies that comply with the Americans with Disabilities Act. Among the topics covered are job interview questions, making reasonable accommodations, preventing discrimination, and pre-employment medical exams. Call (800) 526-7234 (voice/TTY) or go to http://janweb.icdi.wvu.edu.
- ☆ The National School Boards Association maintains an HIV/AIDS policy database that includes workplace policies. Call (703) 838-NSBA or go to www.nsba.org/schoolhealth.
- ☆ The National AIDS Fund operates a Workplace Resource Center with staff who can offer assistance in establishing and maintaining effective policies and practices. Call (888) 234-AIDS or go to www.aidsfund.org/workplac.htm.

Continued

☆ The Society for Human Resource Management has an online *AIDS Guide* to assist human resource professionals with handling workplace issues such as healthcare insurance, long-term and short-term disability insurance, staff training, and workplace-related legislation. Go to www.shrm.org/diversity/aidsguide.

☆ The National Education Association offers *Responding to HIV and AIDS* in English and Spanish, a booklet that addresses issues that affect school employees. Call (800) 718-8387 or visit the website of the NEA Health Information Network at www.neahin.org.

☆ The American Red Cross sponsors workplace HIV/AIDS programs that can provide training and materials. Contact your state or local chapter for more information, which can be located through www.redcross.org.

Discrimination complaints:

☆ Complaints about violations of the Title I (employment) provisions of the ADA by units of State and local government or by private employers should be filed with the Equal Employment Opportunity Commission. Call 800-669-4000 (voice) or 800-669-6820 (TDD) to reach the field office in your area.

☆ The U.S. Department of Justice provides information about the Americans with Disabilities Act through a toll-free ADA Information Line. For general information, answers to specific technical questions, free ADA materials, or information about filing a complaint, call (800) 514-0301 (voice) or (800) 514-0383 (TDD). Spanish language service is also available.

☆ Most community or regional AIDS services organizations can connect a person whose rights have been violated with a specialized attorney, often regardless of ability to pay. Consult a telephone directory or call your local health department.

☆ The AIDS Coordination Project of the American Bar Association serves as a resource center for pro bono (no cost) programs serving people with HIV/AIDS. Staff are available for consultation on planning AIDS-related legal workshops and assisting in the development of appropriate written materials. Among their resources are a periodically updated *Directory of Legal Resources for People with AIDS and HIV* and a publication entitled *Perspectives on Returning to Work: Changing Legal Issues and the HIV/AIDS Epidemic*. Contact (202) 662-1025, e-mail to aidsproject@abanet.org, or go to www.abanet.org/irr/aidsproject/home.html.

Information for employees living with HIV:

☆ The Social Security Administration operates a confidential hotline for information on the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. Call (800) 772-1213 or (800) 325-0778 TTY. A publication entitled *A Guide to Social Security and SSI Disability Benefits for People with HIV Infection* is online in English at www.ssa.gov/pubs/10020.html and in Spanish at www.ssa.gov/espanol/10920.pdf.

☆ The HIV/AIDS Treatment Information Service of the U.S. Department of Health and Human Services is the central resource for federally-approved treatment guidelines for HIV and AIDS. The service is staffed by multilingual health information specialists who answer questions on HIV treatment options. Call (800) HIV-0440 or go to www.hivatis.org.

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Section 3. Privacy

SAMPLE POLICY:

> Pupils or staff members are not required to disclose HIV infection status to anyone in the education system. HIV antibody testing is not required for any purpose.
>
> Every employee has a duty to treat as highly confidential any knowledge or speculation concerning the HIV status of a student or other staff member. Violation of medical privacy is cause for disciplinary action, criminal prosecution, and/or personal liability for a civil suit.
>
> No information regarding a person's HIV status will be divulged to any individual or organization without a court order or the informed, written, signed, and dated consent of the person with HIV infection (or the parent or guardian of a legal minor). The written consent must specify the name of the recipient of the information and the purpose for disclosure.
>
> All health records, notes, and other documents that reference a person's HIV status will be kept under lock and key. Access to these confidential records is limited to those named in written permission from the person (or parent or guardian) and to emergency medical personnel. Information regarding HIV status will not be added to a student's permanent educational or health record without written consent.

EXPLANATION:

Although it is difficult for some people to accept, there is no compelling reason why school authorities must always know if a student or staff member is living with HIV infection. When balancing the right to privacy with the duty to protect the public's health, policymakers should always come down on the side of respecting the privacy of people with HIV infection and their families for several reasons:

- ☆ If HIV infection becomes public knowledge, the person or family might become a target of hurtful stigma or hostility.
- ☆ Fear-stoked rumors and misinformation can disrupt the school and community. Confidentiality helps prevent harmful distractions to learning.
- ☆ A strong confidentiality policy makes it easier for a student, family member, or staff member to come forward and discuss private matters when any kind of need arises. Families have to be able to trust school officials.
- ☆ Parents might wish to hold back telling a young child about HIV until the child reaches a certain level of understanding and maturity. When and what to tell a child are delicate matters.
- ☆ A person who trusts in a confidentiality policy is more likely to take the HIV antibody test, and to seek treatment if necessary. Adolescents tend to be especially concerned about anyone finding out they want to be tested.
- ☆ The information is not needed to enhance safety. The prudent attitude is to assume that *anyone* at *any* time could potentially transmit HIV. Consistent enforcement of infection control guidelines (Section 4) is a more reliable prevention measure than a disclosure requirement. After all, a great many people who are infected with HIV have not been tested and do not know about their infection.

Of course, *voluntary* disclosure to the district superintendent, principal, or school nurse can often benefit the person with HIV infection. These professionals are in a position to smooth the way for coordination with medical providers so that, for example, a student with HIV infection does not receive an inappropriate vaccine. Informing school officials allows them to better enforce confidentiality procedures and provides time to plan for preventing discord in the community (Chapter III).

HAWAII:
Voluntary disclosure

Parents or legal guardians have the right to decide whether school personnel, including principals, teachers, nurses/ health aides, or others, should be made aware of a child's HIV status.

1994

THE LEGAL CONTEXT:

Protecting the confidentiality of private medical and personnel information is primarily a state responsibility. Though many states have laws that specifically address HIV infection and AIDS, the details vary considerably. In general, school staff members expose themselves to criminal penalties and/or civil lawsuits if they violate a person's privacy.

DENVER:
Voluntary disclosure

Any student infected with HIV generally will be identified by the school district only when the district receives direct information from the student or his parent/guardian about his medical diagnosis.

To encourage such disclosure, the district will endeavor to treat such students in a fair, nondiscriminatory, and confidential manner consistent with the district's legal obligations.

1994

Several states require health departments to report the names of students with HIV infection to school principals, despite assurances from public health authorities that it is not necessary or helpful. School decision makers need to investigate and understand the parameters they have to work within. They also need to keep their policies current as laws change and courts issue rulings. The state department of education, state department of health, or tribal council should be able to provide accurate guidance.

On "the need to know"

"The concept of a non-family member's need to know about a child centers on how much disclosure...will aid the person to help the child and how it will enable the person to protect him or herself.

"The former consideration must be left to the parent, for few people...can claim to add to the health of the child... The latter issue is moot if educators learn to use universal precautions around body waste and fluids."[8]

Nationally, the Family Educational Rights and Privacy Act of 1974 (FERPA, also known as the Buckley Amendment) places certain privacy restrictions on student records maintained by schools that receive federal funds. Relevant highlights include:

- ☆ Written parental consent, signed and dated, is required before a school administrator can share information in student records (including health records).
- ☆ Schools must inform students and parents of their privacy rights. These include the right to review and correct information in school records.
- ☆ Schools must have written policies and procedures that govern record keeping.
- ☆ A student's records can be disclosed if "the proper school official" determines a request involves "a legitimate educational interest." The school's record keeping

policies must outline the criteria for determining who is "the proper school official" and what is "a legitimate educational interest," and describe a process for clearly documenting decisions about disclosure.

- ☆ Information that could protect a person's health or safety *can* be disclosed to appropriate people in an emergency.
- ☆ Notes made and personally kept by a teacher, nurse, or other staff members are not considered official student records.

To prevent being blamed for a leak or rumor, some say an employee should *avoid* knowing or speculating if someone at school has HIV infection.

FERPA establishes *minimum* standards; state laws can have tighter restrictions. (The sample policy language at the beginning of this section goes beyond what federal law requires.)

In addition to FERPA, the Federal Individuals with Disabilities Education Act (IDEA) mandates the confidentiality of name-recognizable records of any student who receives special educational services.

IMPLEMENTATION:

Staff members who are well-briefed on confidentiality and record keeping policies are better prepared if someone unexpectedly discloses HIV infection. Perhaps a colleague might explain a bout of chronic fatigue. An adolescent might share personal information with a trusted counselor. A special education planning team could find out about HIV infection from a medical evaluation. Or, a child might spontaneously reveal that a family member is seriously ill with a complication of HIV infection. Staff members need to know that they cannot share private medical information with anyone else without signed consent. Disclosure must always remain a personal decision.

There are several things a staff member can do to help a young person who privately discloses HIV infection. The staff member could caution the person about the possible consequences of further disclosure. He or she could help

SOUTH DAKOTA: Teachers' Code of Professional Ethics

In fulfilling their obligations to the students, educators shall...

(8) Keep in confidence information that has been obtained in the course of professional service, unless disclosure serves professional purposes or is required by law.

Professional Practices and Standards Commission, undated

MASSACHUSETTS: Adolescent confidentiality

Under [Massachusetts's] public health statute minors may consent to their own dental care and medical testing, diagnosis and treatment in certain circumstances, including HIV infection. This law mandates confidentiality of medical information and medical records...

A growing number of adolescents are choosing to exercise this right and be tested for HIV antibodies. Some of these young persons also choose not to inform their parent(s) or guardian(s) of their test results. In this case, if an HIV infected student informs a member of the school staff, that school staff person must be sure not to violate the student's right to keep this information confidential. Any disclosure of this information requires the student's specific, informed, written consent...

Massachusetts Department of Education Guidelines, 1991

NOTE: Many states have a similar law.

locate an AIDS services organization in the region, or a teen crisis center, or hotline (Appendix B lists state-based AIDS information hotlines). At the same time, the staff member could also explain the positive health care advantages of informing the district superintendent, principal, and/or school nurse while stressing that disclosure is a personal decision. Many organizations cited in this guide can provide guidance on what to do and say that is appropriate to the circumstances.

School staff members working with a younger child with HIV infection should communicate regularly with the child's family about the child's experiences in school. This will help the family determine what to tell the child about his or her condition.

Knowing about another person's HIV infection—and keeping quiet about it—can be an awesome burden. A staff member cannot confide with close colleagues as usual. A counselor might help to cope with such a strain—the counselor doesn't need to know the infected person's identity.

Record keeping tips:

- ☆ School nurses, psychologists, social workers, and others should routinely keep all personal notes about students in locked files.
- ☆ Information about a person's HIV status to be kept confidential should include medical prescriptions and all documentation of discussions, telephone conversations, proceedings, and meetings.
- ☆ Avoid using the name of a person with HIV infection in written documents.
- ☆ Do not give confidential records to an unauthorized person to duplicate or file.
- ☆ Use standardized informed consent forms for permitting access to confidential information or disclosure of information.
- ☆ Consent forms themselves should be treated as confidential information, because they often contain sensitive details.
- ☆ The outside of a folder of confidential information should list the names of people permitted to access it.
- ☆ Written permission for someone to access a file should specify the person's name, not position, so that a later person in the same position does not automatically have access.

RESOURCES:

- ☆ Advice, assistance, and/or referrals on disclosing HIV status are available from your area's People With AIDS Coalition, community-based AIDS organization, or AIDS foundation. The CDC National STD and AIDS Hotline at (800) 342-AIDS can provide names of such organizations in your area.
- ☆ Contact your state's department of education or health for information on state laws governing confidentiality.
- ☆ For more information about the Family Educational Rights and Privacy Act (FERPA) and the Protection of Pupil Rights Amendment (PPRA), or to file complaints about violations, contact the Family Policy Compliance Office at the U.S. Department of Education at (202) 260-3887 or go to www.ed.gov/offices/OM/fpco/index.html. This office actively provides advice, guidance, training, and technical assistance to officials of state and local education agencies to assist them in understanding and complying with FERPA
- ☆ The American School Health Association (ASHA) offers *Guidelines for Protecting Confidential Student Health Information*. Call (216) 678-1601 or go to www.ashaweb.org.
- ☆ EDLAW offers *Education Records: A Manual* with guidance on the laws governing the creation, maintenance, disclosure, and destruction of education records. Call (954) 966-4489 or go to www.edlaw.net/publications/edrecords.html.
- ☆ The Model State Public Health Privacy Project of the Georgetown University Law Center has collected state confidentiality laws pertaining to HIV and offers many resource documents and helpful weblinks concerning privacy. Go to www.critpath.org/msphpa/privacy.htm.

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Section 4. Infection Control

SAMPLE POLICY:

> All employees are required to consistently follow infection control guidelines in all settings and at all times, including playgrounds and school buses. Schools will operate according to the standards promulgated by the U.S. Occupational Health and Safety Administration for the prevention of blood-borne infections. Equipment and supplies needed to apply the infection control guidelines will be maintained and kept reasonably accessible. *Designate* shall implement the precautions and investigate, correct, and report on instances of lapse.
>
> A school staff member is expected to alert the person responsible for health and safety issues if a student's health condition or behavior presents a reasonable risk of transmitting an infection.
>
> If a situation occurs at school in which a person might have been exposed to an infectious agent, such as an instance of blood-to-blood contact, school authorities shall counsel that person (or, if a minor, alert a parent or guardian) to seek appropriate medical evaluation.

EXPLANATION:

HIV serves as a good reminder to apply common sense health and safety rules; specifically, a) everyone at school need to consistently follow infection control guidelines, students and staff members alike, all the time, and b) school officials need to routinely enforce their communicable disease policies. Although HIV transmission is unlikely to occur at school, other viruses are more transmissible. For example, exposure to hepatitis B virus causes infection much more often than similar exposures to HIV.[9]

Healthy skin is a trustworthy barrier against infection by HIV. A wound, abrasion, or seriously chapped area could theoretically allow HIV transmission, but only if an adequate amount of infected blood entered a person's body through the skin break. Infection could also theoretically occur if infected blood is in contact for a prolonged period with a mucous membrane (the moist tissue that lines open body passages, such as in the mouth, nostrils, vagina, or around the eyes). However, systematic investigations of several thousand cases of medical workers who had infected blood spilled or splashed onto them indicate that these risks are very low.

Suggested infection control guidelines are listed on the next page, adapted for schools from the well-known "universal precautions to prevent the spread of bloodborne pathogens in health care settings" prepared by health and safety experts. They are called universal because they need to be applied *at all times* and *with all persons* to reliably prevent infection by HIV and other disease-causing agents.

Communicable disease policies should include a provision to alert a person (or parent) if there is a well-founded concern that he or she might have been exposed to a serious infection at school. For example, if a child is bitten deeply enough to draw blood, *and* the biter has a bleeding mouth sore, school authorities ought to report the

> *Theoretical risk*
>
> An expert might concede a "theoretical risk" of HIV infection in a particular scenario, however unlikely.
>
> As scientists use the term, it means an event has never happened, and probably will not happen—but is not impossible. Science cannot provide an absolute guarantee. It is not possible to prove that a situation can never happen.

INFECTION CONTROL GUIDELINES FOR SCHOOLS

*Follow these guidelines at **all** times and with **all** individuals to prevent infection with HIV, hepatitis B virus, and other disease-causing agents:*

Caring for Wounds

- ☆ A person with a bleeding wound or bloody nose should apply pressure on it. If necessary, another person can help by pressing the bleeding person's hand.
- ☆ Keep skin cuts, abrasions, and sores clean and covered.

Do not be afraid to help a bleeding person.

- ☆ Use a barrier to avoid direct contact with blood (or any body fluid that might contain blood). Use latex gloves if possible, or whatever is handy such as clothing or a thick wad of paper.

Cleaning Up

- ☆ Remove each glove without exposing skin to the glove's exterior.
- ☆ Always wash hands promptly and thoroughly with soap and warm water after contact with blood or body fluids that might contain blood, even if gloves or other barriers were used.
- ☆ Wash hands with powder or liquid soap, and dry with disposable towels.

Hand washing helps prevent transmission of many kinds of disease-causing organisms

- ☆ Use tissues, paper towels, or moist towelettes to clean up small amounts of blood.
- ☆ Clean surfaces where blood or other body fluids were spilled with a germicidal cleaning agent. Common bleach diluted at one part bleach to 100 parts water (three tablespoons per gallon) can be used: a bleach mixture loses its strength within a day.
- ☆ Cover spills of blood, vomit, and urine with absorbent sweep material to prevent fluids from spreading, then clean it up using standard procedures.

Disposal

- ☆ Do not reuse thin latex gloves. Rubber utility gloves can be cleaned, but discard any that are torn, punctured, cracked, or otherwise deteriorated.
- ☆ Discard in a sturdy plastic bag all bandages, disposable gloves, and materials used in cleaning spilled blood. Tie the bag and place it into a leakproof container where it will not be disturbed until picked up for disposal.
- ☆ Rinse and then seal a child's blood-stained clothes in a plastic bag to send home for laundering.

Supplies

- ☆ First aid kits should include:
  - ❑ Disposable latex gloves in several sizes
  - ❑ Absorbent bandages and gauze pads in a variety of sizes
  - ❑ Antiseptic pre-moistened towelettes
  - ❑ Leakproof plastic bags with ties
- ☆ Place secure sanitary napkin disposal containers in rest rooms.
- ☆ Stock science laboratories, sewing rooms, and shops with secure disposal containers for items that come into contact with blood.
- ☆ Playground monitors and athletic trainers should carry a pouch containing latex gloves, bandages, and towelettes.

Prevention

- ☆ Teach students to take care of their own minor routine scrapes and cuts, and to wash their hands before and afterwards.
- ☆ Personal items such as toothbrushes, towels, or razors should not be shared at school.
- ☆ Keep school grounds clean of broken glass and other sharp objects.

School health services personnel should use the more detailed guidelines on universal precautions for health care settings, available from the CDC National AIDS Clearinghouse.

incident to the child's parent and suggest a medical evaluation. It is not necessary to reveal information about the biter, because the medical evaluators should consider the possible transmission of a variety of pathogens through saliva or blood. Such an alert should be standard school procedure, whether or not HIV is known to be involved.

Hepatitis B virus

Some 300,000 Americans become infected with hepatitis B virus (HBV) every year, many more than the number infected with HIV. An estimated 1,200,000 Americans are living with chronic hepatitis infection. Each year 4,000–5,000 die from the chronic liver disease the virus can cause.

Unlike HIV, HBV can survive in dried blood and on environmental surfaces for up to two weeks. Unlike HIV, urine can contain it. Concentrations of HBV in blood are usually much higher than of HIV.

THE LEGAL CONTEXT:

Health and safety laws are primarily state or tribal responsibilities. Enforcement responsibility typically belongs to local authorities.

The U.S. Occupational Safety and Health Administration (OSHA) enforces standards on the private sector nationwide, including private and religious schools. The *Occupational Exposure to Bloodborne Pathogens* standards require employers to be able to show:

- ☆ a written infection control plan
- ☆ a staff training program, with records kept for three (3) years
- ☆ availability of appropriate protective items such as latex gloves, antiseptic cleaning supplies, and secure waste disposal bags
- ☆ housekeeping schedules
- ☆ procedures for medical follow-up and counseling after a blood exposure incident, with confidential medical records of the incident kept for thirty (30) years

OSHA's regulations also call for employers to identify those who are "reasonably anticipated" to be exposed to blood as part of their job duties. Some schools put nurses, custodians or coaches in this category: expert guidance might be necessary to decide whom to include. The school must then offer the designated employees hepatitis B vaccine and intensive prevention training. An employer must also pay for the medical evaluation of any employee who reports a blood exposure incident to the personnel office within 24 hours.

A child's adage

If it's wet...
and it's not yours,
don't touch it.

Individual states decide on standards for public sector employees. Nearly half the states have adopted guidelines that are at least as strict as OSHA's. Within states that do not have any standards that apply to school employees, many school districts adopt the OSHA standards for themselves. OSHA funds consultation services in every state to provide implementation assistance: telephone numbers are listed in Appendix B.

Concerning the "duty-to-warn" someone who appears to be at risk of being infected by a person with HIV infection, legal experts generally conclude that, unlike suspected cases of child abuse, education personnel are not legally obligated to intervene or report suspicions. However, some states' duty-to-warn statutes—laws that primarily address psychotherapists—might be interpreted to include school psychologists or counselors. Consult an attorney familiar with your state's health laws for guidance.

Meanwhile, a school staff person aware of such a danger can do two things: make every reasonable effort to counsel the person with HIV infection on his or her obligation to protect others; and promote good quality HIV prevention education for everyone in the school community.

MICHIGAN: Model communicable disease policy

Irrespective of the disease presence, routine procedures shall be posted and used and adequate sanitation facilities and supplies will be available for handling blood or body fluids within the school setting or school buses. All school personnel will be trained in the proper procedures for handling blood and body fluids and these procedures will be strictly adhered to.

1991

Can a person with HIV infection spread other diseases?

Many of the illnesses that develop in people with HIV infection are caused by bacteria, viruses, fungi, or parasites that are commonly present in our everyday environment. They are called "opportunistic infections" because they take advantage of a person's weakened immune system. Individuals with normal, fully functioning immune systems routinely cope with these pathogens and have no reason to fear them.

Contagious diseases like measles, chicken pox, flu, or mumps are no more—or no less—likely to be transmitted by a person with HIV infection. When a student with HIV infection also has a contagious illness, the problem for a school to address is the secondary infection, not HIV. Communicable disease policies concerning infections that *are* transmissible at school should still apply (Section 1).

IMPLEMENTATION:

Every staff member should be trained to calmly and routinely apply infection control guidelines whenever blood is present whether or not their duties bring them into direct contact with students: teachers, administrators, custodians, food service workers, coaches, substitute teachers, bus drivers, and office workers. Effective training techniques are described in Section 8.

Tuberculosis

Tuberculosis (TB) is a serious public health problem. News reports have made some worry that people with HIV infection are mostly responsible for a new epidemic of TB. The true danger of transmission, however, lies with *any* person who has an active case and is spreading tuberculosis bacteria through the air.

Although most people who acquire TB bacteria never develop the disease, a person with HIV infection is much more likely to progress to an active case. This means that a person with HIV infection is the one who has the most to worry about acquiring TB *from* others at school.

Every person with HIV infection should be screened for TB under a doctor's care. Preventing TB infection from becoming actual disease is one reason why early detection and care of HIV infection is very important.

A person with TB infection cannot spread TB bacteria soon after beginning the proper medical treatment, nor while maintaining treatment.

The prevention and control of tuberculosis is a distinct policy issue. Most people with HIV infection do not have TB. Most people with TB infection do not have HIV.

Students should learn about the guidelines in first aid and safety classes. Encourage family members to reinforce the guidelines at home. Some schools include illustrations of prevention concepts in student handbooks. The guidelines need to become second nature to everyone.

Procuring and regularly replacing the basic supplies required to practice infection control guidelines is a necessary budget expense. Such supplies need not be elaborate or costly: many are inexpensive when bought in bulk from distributors. Hand washing facilities should be reasonably accessible to all (though every room does not need a sink). Maintenance supply stocks should include absorbent sweep material for fluid spills.

HIV is considered relatively fragile compared to other disease causing viruses. It is quickly rendered harmless by heat or lack of moisture. Virtually all disinfectants effectively destroy HIV, including 70 percent alcohol or a dilute solution of bleach mixed 1:100 in water (3 tablespoons, or a little under ¼ cup, per gallon). Disinfect soiled carpet with a germicidal cleaning agent.

Implementation of infection control guidelines should not wait until a case of HIV infection is known: there might already be someone in the school with the virus. To help assure consistent enforcement, school administrators should encourage students and staff members to report instances when the simple guidelines were not used.

RESOURCES:

- ☆ *Occupational Exposure to Blood-Borne Pathogens: Implementing OSHA Standards in School Settings*, a guide that includes sample policies, forms, and checklists, is available from the National Association of School Nurses at (207) 883-2117 or www.nasn.org.
- ☆ The Health Information Network of the National Education Association (NEA) has *Guidelines for Handling Blood and Other Body Fluids in School* at www.neahin.org/responding/guide.html. Call (202) 822-7570, access their automated resource line at (800) 718-8387, or e-mail to info@neahin.org.
- ☆ CDC has an easy-to-read booklet entitled *Exposure to Blood What Health-Care Workers Need to Know* and similar resources at www.cdc.gov/ncidod/hip/Blood/hiv.htm.
- ☆ CDC's National Institute of Occupational Safety and Health offers guidelines entitled *Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health Care Settings*, and other resources, at www.cdc.gov/niosh/bbppg.html. For additional information call (800) 356-4674.
- ☆ Information about the bloodborne pathogens regulations of the Occupational Safety and Health Administration (OSHA) can be found at www.osha-slc.gov/SLTC/bloodbornepathogens/index.html. Questions about how the regulations apply to different employment situations are answered in various OSHA Standards Interpretation and Compliance Letters available on the website. For more assistance contact the OSHA consultation service in your state, listed in Appendix B.
- ☆ Local chapters of the American Red Cross have materials and can provide training in universal precautions. Infection control personnel in local hospitals or Emergency Medical Services programs might also be able to offer assistance in policy development and/or training.
- ☆ CDC's Division of Tuberculosis Elimination has complete information on this disease. Go to www.cdc.gov/nchstp/tb.

☆ ☆ ☆

Section 5. HIV and Athletics

SAMPLE POLICY:

> The privilege of participating in physical education classes, athletic programs, competitive sports, and recess is not conditional on a person's HIV status. School authorities will make reasonable accommodations to allow students living with HIV infection to participate in school-sponsored physical activities.
>
> All employees must consistently adhere to infection control guidelines in locker rooms and all play and athletic settings. Rulebooks will reflect these guidelines. First aid kits must be on hand at every athletic event.
>
> All physical education teachers and athletic program staff will complete an approved first aid and injury prevention course that includes implementation of infection control guidelines. Student orientation about safety on the playing field will include guidelines for avoiding HIV infection.

EXPLANATION:

Many people are particularly worried about HIV transmission in school sports programs. Although most athletic policy concepts are covered in other sections of this document, concerns in your community might justify targeted attention to HIV and athletics.

Cuts, abrasions, and nosebleeds can be fairly common on the playing field, depending on the sport. Yet, studies released by CDC in February 1995 conclude that the potential risk of infection during competition is extremely low.[10] It is unlikely that an adequate amount of one person's blood could enter another person's body during competition, even in a contact sport. To date, there has never been a confirmed case of HIV transmission during athletic activities. Most state school athletic associations do not allow game cancellations due to fear of AIDS—a team that refuses to play another team typically forfeits the contest. CDC emphasizes that the principal risks faced by athletes are related to off-the-field activities.

There is no medical reason to disallow a student or school staff member from participating in recess, physical education, or a school athletic program if he or she wishes and is able to do so. Professional athletes have demonstrated that people with HIV infection can perform at full capacity. With the help of a physician and family members, the person living with HIV infection should be the one to decide if his or her health status allows participation in athletic activities. Physicians often recommend moderate exercise for people with HIV infection.

> "A participant in an interscholastic athletic contest or practice faces virtually no risk of an infectious disease like HIV *as long as* infectious control precautions and common sense management of injuries are used."
>
> *National Federation News*

THE LEGAL CONTEXT:

Disallowing participation in physical education and athletic programs primarily on the basis of HIV infection violates federal civil rights laws, notably the Americans with Disabilities Act (ADA: see Section 1 and Appendix E). A school must allow a student with HIV infection to join an athletic team if the student is "otherwise qualified," that is, if the student's skills and physical condition satisfy the same qualifications everyone else must

AAP: HIV and athletes

"A physician counseling a known HIV-infected athlete in a sport involving blood exposure, such as wrestling or football, should inform him [sic] of the theoretical risk of contagion to others and strongly encourage him to consider another sport...

"...athletic equipment (e.g., wrestling mats) visibly contaminated with blood should be wiped clean with fresh bleach solution and allowed to dry before reusing...

"Saliva does not transmit HIV. However, because of potential fear on the part of those providing cardiopulmonary resuscitation, breathing (Ambu) bags and oral airways for use during cardiopulmonary resuscitation should be available in athletic settings for those who prefer not to give mouth-to-mouth resuscitation."

"Athletes should...be made aware of the hazards of needle sharing for illicit drug use, including steroids...

Committee on Sports Medicine and Fitness, American Academy of Pediatrics

satisfy. Schools have to make reasonable accommodations, if needed, to allow a student to participate.

Similarly, the right of an athletic staff member who is living with HIV infection or AIDS to keep his or her job is also protected, as long as the employee can continue to fulfill the "essential functions" of the job with "reasonable accommodations" (Section 2).

Steroid use and HIV

"Sharing needles or syringes with an HIV-infected person even once presents a significant risk of becoming infected with HIV. The virus from an infected person can remain in a needle or syringe and then be injected directly into the next person who uses the needle. Injectable drugs include steroids, hormones, and vitamins.

"Experts agree that there is a risk of HIV infection from sharing needles used to inject steroids and that steroid use among adolescents is rising. Two cases have been reported in which bodybuilders who shared needles to inject steroids became infected with HIV. Detailed personal histories revealed that neither individual had participated in any other risk behaviors. Injectable human growth hormone, a naturally occurring hormone that is hard to detect, is becoming a popular substitute for banned steroids despite the dangers of using it for such a purpose.

"For those who continue to inject any drug or other substance outside medical supervision, the Centers for Disease Control and Prevention, the Center for Substance Abuse Treatment, and the National Institute on Drug Abuse have issued provisional guidelines for cleaning needles; the guidelines are available from the CDC National AIDS Clearinghouse."

CDC National AIDS Clearinghouse

IMPLEMENTATION:

Everyone should assume that *anyone* could have HIV, hepatitis B virus, or another bloodborne pathogen. It is therefore prudent that coaches, team managers, and student athletes all learn and practice infection control guidelines for handling blood (and other body fluids that might contain blood). This should be an integral part of the first aid training courses required of all physical education and athletic program staff.

Remove an athlete from play immediately if he or she appears to be bleeding. Keep the person out of competition until the bleeding is stopped and the wound

On testing athletes for HIV

"There is no medical or public health justification for testing or screening for HIV infection prior to participation in sports activities."

World Health Organization

"Routine HIV testing of all athletes is unnecessary, impractical, unmanageable, and costly for many reasons."

CDC National AIDS Clearinghouse

is cleansed and covered. An athlete should change a blood-soaked uniform before returning to the field.

The National Federation of State High School Associations offers specific model rules regarding bleeding for twelve common school sports, including time-outs, substitutions, reintroduction, etc. These should be added to rulebooks everywhere.

> *Suggestion:*
>
> Practice an infection control "game plan" so that procedures, roles, and responsibilities are clear to one and all.

RESOURCES:

- ☆ CDC's Division of HIV/AIDS discusses HIV and athletics on its *Frequently Asked Questions on HIV/AIDS* page at www.cdc.gov/hiv/pubs/faqs.htm.
- ☆ Your state-level high school activities association is a good source of information on athletic programs and trainings for athletic department staff.
- ☆ The National Federation of State High School Associations (NFHS) posts *Communicable Disease Procedures* to prevent HIV infection at www.nfhs.org/procedures.htm. Call them at (317) 972-6900 for advice on sports rules.
- ☆ The National Athletic Trainers' Association (NATA) posts *Blood Borne Pathogens Guidelines for Athletic Trainers* at www.nata.org/publications/otherpub/bloodpathogens.htm.
- ☆ The National Collegiate Athletic Association (NCAA) has their constantly updated *NCAA Sports Medicine Handbook* online. Guideline 2h, "Blood-Borne Pathogens and Intercollegiate Athletics," is available at www.ncaa.org/sports_sciences/sports_med_handbook/2h.pdf.
- ☆ The American Academy of Pediatrics has a detailed policy on *Human Immunodeficiency Virus and Other Blood-borne Viral Pathogens in the Athletic Setting* at www.aap.org/policy/re9821.html.
- ☆ The Occupational Safety and Health Administration (OSHA) has issued a letter of clarification on the "Applicability of bloodborne pathogens standard to athletic trainers; handling of contaminated laundry" at www.osha-slc.gov/OshDoc/Interp_data/I20000925.html. For more assistance contact the OSHA consultation service in your state, listed in Appendix B.
- ☆ The American Association for Health Education offers *HIV Prevention Education for Physical Educators, Coaches and Athletic Trainers*. Call (800) 213-719 or go to www.aahperd.org/AAHE/programs-hiveducation.html.
- ☆ The federal Center for Substance Abuse Prevention operates a National Clearinghouse for Alcohol and Drug Information. Resource guides and educational materials are available on injection drug use prevention and the link between alcohol use and HIV infection. Call (800) 729-6686 to speak with a prevention specialist in English; (877) 767-8432 Spanish, (800) 487-4889 TDD, or go to www.health.org.

☆ ☆ ☆

Section 6. HIV Prevention Education

SAMPLE POLICY:

The goals of HIV prevention education are to promote healthful living and discourage the behaviors that can put a young person at risk of acquiring HIV. The educational program will:

- be taught at every level, Kindergarten through grade twelve;
- use methods demonstrated by sound research to be effective;
- be consistent with community standards;
- follow content guidelines prepared by the Centers for Disease Control and Prevention (CDC);
- be appropriate to students' developmental levels, behaviors, and cultural backgrounds;
- build knowledge and skills from year to year;
- stress the benefits of abstinence from sexual activity, alcohol, and other drug use;
- include accurate information on reducing risk of HIV infection;
- address students' own concerns;
- include means for evaluation;
- be an integral part of a coordinated school health program;
- be taught by well-prepared instructors with adequate support; and
- involve parents and families as partners in education.

Parents and guardians shall have convenient opportunities to preview all HIV prevention curricula and materials, and be provided assistance to discuss HIV infection with their children. If a parent or guardian submits a written request to a principal that a child not receive instruction in specific HIV prevention topics at school, and assures that the topics will be discussed at home or elsewhere, the child shall be excused without penalty or stigma.

The education system will endeavor to cooperate with HIV prevention efforts in the community that address out-of-school youth and youth in situations that put them at high risk of acquiring HIV.

EXPLANATION:

Education for prevention is the most important weapon in the battle against HIV—and will undoubtedly remain so for the foreseeable future. For more than a century America's schools have played a central role in controlling disease epidemics. This is because virtually all young people attend, and schools have the capacity to teach prevention *before* students become sexually active or use alcohol or other drugs. Opinion surveys consistently find overwhelming public and parental support for teaching HIV prevention in schools.

Compared to traditional academic subjects, the purpose of HIV prevention education is different and more ambitious—to affect students' conduct after school hours. Different teaching strategies are required because simply learning facts about HIV and AIDS, while necessary, is rarely enough on its own to affect a person's conduct. After all, if factual knowledge alone mattered, most adults would not smoke, drink heavily, or be overweight.

"Health education is basic to the basics."
Ernst Wynder
American Health Foundation

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"First Things First: What Americans Expect from Public Schools"

From a 1994 national survey by Public Agenda, a non-profit, non-partisan research group:

Finding 5: Most Americans are not preoccupied by concerns about sex education and multi-culturalism that have caused such acrimonious debate in many communities.

Finding 6: People want schools to teach values. They especially want schools to emphasize those values that allow a diverse society to live together peacefully.

Finding 7: There is strong support for public schools playing a central role in sex education—an overwhelming consensus that parents need help. However, on questions of premarital sex and homosexuality, there are sharp divisions over how graphic and morally judgmental sex education should be.

This study, along with many others conducted on this issue, found strong support for sex education in the schools. Only 14% of Americans feel that schools spend too much time on sex education, and a majority of Americans want sex education to begin by sixth grade…

[A total of] 97% say the schools should teach students about the dangers of sexually transmitted diseases, including AIDS… 35% would begin in elementary schools and 51% say this should begin in junior high.

Although the need for HIV prevention education is compelling, education leaders also have to be realistic about what schools can reasonably accomplish. Personal conduct is difficult to sway. Young people are greatly influenced by their friends, the media, and the general culture. Yet even modest results mean that some youth will successfully avoid HIV infection.

"HIV prevention programs are doomed to failure if they are expected to protect 100% of people from disease 100% of the time."

Center for AIDS Prevention Studies

What should schools teach about HIV prevention?

CDC suggests specific topics by grade in a set of guidelines that includes an emphasis on compassion for people with HIV infection (see Resources).

Few doubt that the only sure way to avoid HIV infection is to consistently abstain from sexual intercourse and injectable drugs. All major HIV prevention curricula for schools emphasize this: all are "abstinence-based."

People disagree, however, on whether education should be "abstinence-*only*," or whether schools should stress abstinence but also teach those students who are already taking chances—and those who will take chances someday—how to reduce their risk of HIV

"Wave after wave of infection"

"Prevention efforts have helped stabilize infection rates overall and may have contributed to a decline in infection in older white males. But it is now clear that as each generation of young Americans comes of age, they face an AIDS epidemic not unlike that faced by the generation before.

"In every group, by race and gender, there is substantial increase in the rate of infection as individuals enter their late teens and early twenties, with rates peaking in the mid-to late-twenties.

"The danger is that we will become complacent, accept that at least 40,000 people will become infected each year, and that wave after wave of HIV infection will endanger our nation's youth. Sustained, targeted prevention for each group entering young adulthood is what will keep these waves from developing."

National Cancer Institute

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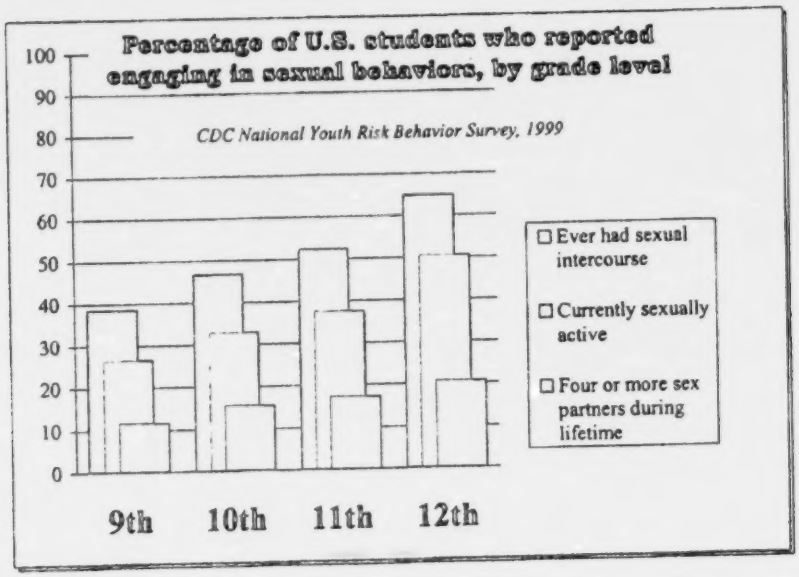

infection. Some argue that if a student does not learn HIV prevention methods from a parent, nor learn them in school either, the student might never know potentially life-saving information.

Many people who oppose HIV education are concerned that schools implicitly sanction risky conduct if teachers do not consistently discourage it. They worry that classroom discussion might stimulate curiosity and experimentation. Yet credible research studies confirm that school-based sex education does not hasten onset of intercourse, increase frequency of intercourse, or increase numbers of sexual partners.[11] To date, there is no reliable evidence that abstinence-only curricula are effective at reducing risk behaviors. There is also no evidence they do not work. The educational programs that rigorous evaluations have found to be the most successful all teach a two-pronged message: "You shouldn't engage in sex yet, but if you do, protect yourself."

> "If you want us to make our own decisions, then we need *all* the information, not just half of it."
>
> *Heather de Wit, 18*
> *National Youth Summit on HIV Prevention and Education, 1995*

Students are more likely to pay attention to HIV prevention education when the lessons are personally and immediately relevant. Timing is important. For example, the transition from school to another is a particularly vulnerable time when many students are influenced by older students or social groups that are new to them. Education should occur *before* a person becomes sexually active. While many schools have successfully encouraged students to postpone beginning sexual activity, even the best programs have little success at promoting abstinence among those who are already sexually active. Decision makers should examine any available information that sheds light on how local youth are behaving when determining curriculum content and grade levels.

> *Scare tactics don't work*
>
> "Unfortunately, telling, lecturing, taking students to the morgue, and other means of scaring have never been shown to reduce [drug] use and nothing suggests that they ever will."
>
> *Western Regional Center for Drug-Free Schools and Communities*

What works?

In 1994 Douglas Kirby, et al., published a landmark analysis of scientifically credible sexuality and HIV education program evaluations.[12] They identified several characteristics shared by the most effective programs. Though "preliminary and tentative," these characteristics offer the best indication of what works:

☆ *Narrow focus.* The most successful programs emphasize only a limited number of specific goals, such as postponing sexual involvement.

☆ *Based on learning research.* Reflecting recent scientific findings, the programs go far beyond cognitive learning to focus on social influences, individual values, social skills, and group norms (patterns of attitude and behavior). They use a variety of methods to personally engage students and address their concerns, such as small group discussions, simulations, conversations with peer educators, and situation rehearsals.

☆ *Basic, accurate information.* The programs provide student what they need to recognize a risky situation, assess the risks, understand their options for action, and make decisions. A great amount of information or detail doesn't appear necessary.

☆ *Social and media influences.* The programs include critical discussions about pressures from peers and older people, sex and alcohol messages in advertising, and media portrayals of sex or drug use without consequences.

☆ *Clear values message.* The programs aim to reinforce specific personal values and conservative peer group norms by, for example, discussing typical "come-on lines" and effective responses, or exploring reasons why everyone is *not* "doing it."

☆ *Skills modeling and practice.* The programs teach skills and then allow students to repeatedly practice the skills, including how to communicate one's values, how to set limits to intimacy, how to identify a high risk situation, what to do in a high risk situation, and how to avoid such situations in the first place without hurting others' feelings.

☆ *Effective teacher training.* Ranging from six hours to three days' duration, the successful programs' trainings provide information and allow teachers time to practice using teaching strategies.

Summarizing the major differences between effective and ineffective programs, Dr. Kirby emphasized two things: the importance of focused goals and a clear stand on values:

> *"For example, one of the ineffective curricula... asked students to identify reasons for and against having sex, but did not process the discussion beyond the generation of ideas. In contrast, ...one of the effective programs asked students to identify reasons* ***why teens have sex, to identify reasons students should wait to have sex, and then to*** *assess...likely consequences. Given this structure, the student groups usually concluded that the reasons to wait were more compelling."*

Policymakers should critically assess any education program, existing or proposed, to determine if it incorporates the characteristics of effectiveness described in "What works" on the previous page. Find out if other school systems in the region are using the program and if their teachers recommend it. Closely examine a program's claims: Has it demonstrated results? Are the evaluations credible? Were the evaluation studies published in peer-reviewed journals?

What if the HIV education program bothers some parents?

Some parents worry that HIV prevention education is not compatible with their values. School administrators need to use clear criteria for selecting curricula and materials, faithfully follow an established adoption process, and provide parents and guardians convenient opportunities to examine and discuss all materials. School leaders and teachers should make parents feel that they are welcome partners in HIV prevention.

For public health reasons, schools should teach HIV prevention as a matter of course. Nevertheless, schools and districts should also have "opt-out" provisions for those who prefer that their children not learn about certain topics at school. Public school administrators

NEW YORK STATE:
Opt-out policy

No pupil shall be required to receive instruction concerning the methods of prevention of AIDS if the parent or legal guardian of such pupil has filed with the principal of the school which the pupil attends a written request that the pupil not participate in such instruction, with an assurance that the pupil will receive such instruction at home.

Commissioner's Regulations

NEW JERSEY:
Appropriate consultation

The HIV prevention education curriculum shall be developed through appropriate consultation and participation of teachers, school administrators, parents and guardians, students, physicians, members of the clergy, and representative members of the community. The district board of education shall demonstrate prior to the initiation of any education program that such consultation and participation have taken place. The process of consultation shall be continued as the program is revised in future years. Upon the request of parents and guardians, the curriculum shall be made available for their review.

1986

PRESIDENT CLINTON: Directive on religion in school

The following principles are among those that apply to religious expression in our schools...

Religious excusals: Subject to applicable state laws, schools enjoy substantial discretion to excuse individual students from lessons that are objectionable to the student or the student's parents on religious or conscientious grounds. School officials may neither encourage nor discourage students from availing themselves of an excusal option. Under the Religious Freedom Restoration Act, if it is proved that particular lessons substantially burden a student's free exercise of religion, and if the school cannot prove a compelling interest in requiring attendance, the school would be legally required to excuse the student.

Teaching values: Though schools must be neutral with respect to religion, they may play an active role with respect to teaching civic values and virtue, and the moral code that holds us together as a community. The fact that some of these values are held also by religions does not make it unlawful to teach them in school.

Memorandum to the U.S. Secretary of Education, July 1995

need to seriously consider religious objections, which are protected by the Federal Religious Freedom Restoration Act.

Typically, an "opt-out" policy requires a parent or guardian to file a written request to excuse a child from class when specific topics are covered. School officials can in turn ask for assurances that the student will learn about the topics at home or elsewhere. (Of course, a school cannot monitor or enforce such assurances, but the requirement sends an important message.)

Problem behaviors are linked

"Of the leading causes of mortality and morbidity...only six categories of behavior are responsible for most of our major health problems: 1) behaviors that cause unintentional and intentional injuries; 2) alcohol and other drug abuse; 3) sexual behaviors that can result in sexually transmitted diseases including HIV infection, and unintended pregnancies; 4) tobacco use; 5) inadequate physical activity; and 6) dietary patterns that cause disease.

"These behaviors usually are established during youth; persist into adulthood; are interrelated; contribute simultaneously to poor health, education, and social outcomes; and are preventable."

Lloyd Kolbe, Ph.D.
CDC Division of Adolescent and School Health

The broader context:

Youth risk behaviors tend to cluster. An analysis of 1991 Youth Risk Behavior Survey data determined that students ages 13 or younger who initiate sexual intercourse at a young age are also more likely to smoke cigarettes, use spit tobacco, drink alcohol, use steroids, fight, carry weapons, or think about suicide. As they get older, students who began sexual activity by age 13 are at least ten times more likely to have greater numbers of sexual partners as those who did not, twice as likely to become pregnant or cause a pregnancy, and half as likely to practice "safer sex."[13]

The CDC Division of Adolescent and School Health recommends integrating HIV prevention education into a coordinated school health program. Different program components can complement and reinforce each other. For example, teachers can reinforce the skills and attitudes that encourage one behavioral goal by teaching them again and again with different topics. A student who successfully avoids adopting one negative behavior is less likely to adopt others.

Those who leave school early or who drop-in-and-out of school are found, on the average, to engage more often in behaviors that carry a risk of HIV infection than do other youth. Schools should collaborate to the greatest extent possible with community-based programs that reach out to these young people. Consistent messages coming from a variety of sources can help shift youth group attitudes and social norms towards abstinence and the use of protection.

Schools can help youth talk with parents

A 1991 national survey found that the proportion of U.S. high school students reporting having discussed HIV/AIDS with parents was significantly higher among those who had received HIV prevention education in school (63 percent) than among those who had not (49 percent).[14]

A school health program should also include a voluntary parent education component. Many parents understand that they are their children's best teachers on HIV prevention and want professional advice and guidance on handling sensitive issues of sexuality and serious illness. In a 1992 nationwide survey, 76 percent of parents of 10- to 17-year olds who felt they knew a lot about AIDS discussed it with their children, compared to 19 percent of those who felt they knew nothing about AIDS.[15] Teens who reported previous discussion of sexual matters with parents were seven and a half times more

likely to feel able to communicate with a partner about AIDS than those who had not had such discussions.[16]

> **MASSACHUSETTS: Community education**
>
> The [State] Board strongly suggests that schools play a leadership role in developing educational programs on AIDS/HIV for parents and community members who may reinforce the prevention messages presented in the classroom.
>
> *1990*

Other important policy points:

HIV prevention efforts must not overlook special needs students and those in alternative placements. Young people with disabilities need this education as much as others, if not more so because of the danger of exploitation. For a student with limited English proficiency, it might be necessary to teach HIV prevention in his or her native language, perhaps by drawing on a community volunteer.

Evaluation must not stop once a curriculum is selected. Educators can gain useful information about a program's quality and impact through simple evaluation methods such as brief surveys and student feedback questionnaires. Policymakers should expect school administrators and teachers to continually refine education programs.

THE LEGAL CONTEXT:

Education is ultimately a state or tribal responsibility. In the interests of protecting the public's health, more than thirty states have laws or state board policies that mandate HIV prevention education. Other states with strong local control traditions do what they can to encourage local school districts to implement HIV prevention education.

School staff members should be aware that the federal Protection of Pupil Rights Act (a 1994 amendment to the General Education Provisions Act) requires written parental consent before using federal education funds to submit a student...

> *"...to a survey, analysis, or evaluation that reveals information about (1) political affiliations; (2) mental and psychological problems potentially embarrassing to the student or his* [sic] *family; (3) sex behavior and attitudes; (4) illegal, anti-social, self-incriminating and demeaning behavior; (5) critical appraisals of other individuals with whom respondents have close family relationships..."*

IMPLEMENTATION:

Teachers cannot rush through an HIV prevention education program in a few hours and expect to accomplish much. One-shot school assemblies are not likely to permanently affect anyone's behavior.

Program planners can use "behavior mapping" techniques to systematically determine their instructional priorities, select appropriate curricular materials, and decide how to most productively use the limited class time available.[17] Repeated "booster lessons" are generally considered essential. Students' health skills have to be built up year by year, just as their reading and mathematics skills are.

> *On curriculum integrity:*
>
> "Modifications to carefully developed and tested programs, such as deleting 'sensitive' information [or] refusing to spend money on skills building... create barriers to effective programs."
>
> *The President's National Commission on AIDS*

The American School Health Association suggests the option of an interdisciplinary teaching approach in which HIV-related lessons are integrated across the curriculum within other subjects.[18] This could mean, for example, that students track the growth of the epidemic in mathematics class, explore universal topics of life and death in literature class, compare HIV with past epidemics in history class, and learn viral biology in science class *in addition to* learning skills to avoid HIV risk behaviors in health class. (Schools using this approach must take care not to allow academic instruction to completely replace an emphasis on behavioral skills-building.)

Regardless of the curriculum approach used, policymakers need to ensure that teachers have professional development opportunities so that they can feel capable and comfortable with the subject. Most state education departments have teacher training coordinators for HIV prevention who can provide assistance. Administrators should not force personally reluctant teachers to teach HIV prevention because they might not teach it effectively.

Policymakers should also ensure that teachers have the materials they need to teach well: adequate resources for HIV prevention education are usually not a major budget item. Teachers need to feel supported by administrators and policymakers in order to teach with confidence.

Non-curricular activities that are often effective at motivating students include peer teaching, teen theater, viewing panels of the AIDS Memorial Quilt, and discussions with people living with HIV infection. A local AIDS services organization might be able to arrange for a suitable speaker. Caution must be taken that outside speakers are screened for their appropriateness, oriented to the school's policies, and trained in presentation skills. Extracurricular activities should be integral parts of an overall HIV prevention program, not stand-alone events or substitutes for organized instruction.

WEST VIRGINIA:
AIDS education policy

The following components shall be addressed in each county board policy:

Assurance that the educational personnel responsible for classroom instruction receive staff development that will enable them to implement effective AIDS prevention education programs.

Assurance that the programs be taught by qualified professionals who periodically participate in staff development activities that will provide current information related to AIDS education.

Assurance that the program is comprehensive and provides not only knowledge about the disease AIDS, but also has a focus on behaviors and skills necessary to prevent exposure to the virus.

1989

Support for teachers:

"If teachers perceive that they do not have the resources or opportunities to teach HIV/AIDS, they are unlikely to form intentions to do so even if they have positive attitudes toward AIDS education, and even if they believe that other people would want them to teach it."

Dana-Farber Institute

Of students surveyed who have seen the AIDS Memorial Quilt, more than 2/3 reported that seeing the Quilt made them think more about their own chances of getting infected. Almost 90 percent indicated that they would be more willing to take steps to avoid getting infected.

Cost-effectiveness

"HIV prevention efforts need have only a small favorable impact on behavioral outcomes for the program's economic benefits to outweigh the financial costs."

CDC Office of HIV/AIDS

MASSACHUSETTS:
Policy on AIDS/HIV prevention education

AIDS and infection with HIV, the virus that causes AIDS, are serious threats to the lives and health of young people of Massachusetts... Due to prevalent patterns of sexual activity and substance abuse, many of our young people are at significant risk of infection with HIV. Our schools must play a major role in the concerted effort to stop the spread of the virus by helping students make healthy choices about their personal behaviors...

Therefore, the Board of Education of the Commonwealth of Massachusetts urges local school districts to create programs which make instruction about AIDS/HIV available to every Massachusetts student at every grade level. These programs should be developed in a manner which respects local control over education and involves parents and representatives of the community.

The Board believes that AIDS/HIV prevention education is most effective when integrated into a comprehensive health education and human services program. Ideally, content related to various aspects of the AIDS/HIV epidemic (biological, social/historical, ethical, behavioral, interpersonal, statistical) will be spread across several curriculum areas, especially science, social studies, health, home economics, language arts, and mathematics...

[AIDS/HIV] instruction should be offered at all grade levels (including special education classes, programs, schools, and residential facilities) in a developmentally, linguistically and culturally sensitive manner. Special efforts should be made to educate hard-to-reach and high-risk young people, particularly youth who are out of school, are drug-involved, are gay/bisexual, or are members of communities disproportionately affected by the AIDS/HIV epidemic.

Instruction in AIDS/HIV prevention should occur over multiple sessions, in a format which maximizes student interaction. This instruction should respect students' various learning styles. It should increase students' knowledge about AIDS/HIV, allow students to process their feelings about AIDS/HIV prevention, and should encourage the development of positive self-esteem and concrete decision-making, communication and behavioral skills.

At the secondary level, and according to local decisions, AIDS/HIV education should be part of a more complete sexuality education curriculum. This curriculum should include information about sexually transmitted diseases and the value of both sexual abstinence and the use of condoms as disease prevention methods.

The Board recommends that, when possible, persons living with AIDS/HIV be utilized in the classroom to impress upon students the reality of the epidemic and to build compassion and respect for persons affected by AIDS/HIV...

Students should be actively involved in AIDS/HIV educational efforts. Peer education programs and student-initiated projects are especially encouraged in order to develop a sense of students' responsibility for their own behaviors and for community members who are living with AIDS/HIV.

1990

RESOURCES:

General guidance

☆ Contact the HIV/AIDS Education Coordinator at your state department of education (Appendix B) for guidance on program requirements, materials selection, and procurement of materials.

☆ Specialists at the CDC National Prevention Information Network can answer questions, distribute materials, make referrals, and identify resources drawn from several large databases. Many publications are available online at www.cdcnpin.org, or call (800) 458-5231 for personal assistance in English or Spanish, (800) 243-7012 TTY, or e-mail to info@cdcnpin.org. Among the many materials available are

- *Compendium of HIV Prevention Interventions With Evidence of Effectiveness,*
- *Guidelines for Health Education and Risk Reduction Activities*;
- *HIV/AIDS & Persons with Physical and Mental Disabilities: A Guide to Selected Resources;* and
- various sets of policy recommendations.

☆ The Office of Minority Health Resource Center of the U.S. Department of Health and Human Services offers customized database searches, publications, mailing lists, and referrals regarding American Indian and Alaska Native, African American, Asian American and Pacific Islander, and Hispanic populations. Call (800) 444-6472, send e-mail to info@omhrc.gov, or go to www.omhrc.gov/omhrc

☆ CDC provides funding to national nongovernmental organizations to assist national, state, and local efforts to prevent HIV infection among various populations of youth, including youth in high-risk situations. For a list of these organizations with full contact information go to www.cdc.gov/nccdphp/dash.

☆ The website of AVERT, a British charity, provides a good overview of the purposes and characteristics of effective HIV prevention education. Go to www.avert.org/educate.htm.

☆ The Center for AIDS Prevention Studies at the University of California at San Francisco offers the *Best of Prevention Science* website which lists HIV prevention interventions for a variety of populations that have been evaluated for effectiveness. Included is the full text of "School-based programs to reduce sexual risk behaviors: a review of effectiveness" by Kirby, et al. Go to www.caps.ucsf.edu/toolbox/SCIENCEindex.htm.

☆ The Academy for Educational Development offers *Protecting Youth, Preventing AIDS: A Guide For Effective High School HIV Prevention Programs,* a guidebook for school administrators, teachers, health care workers, parents, and students. Call (212) 367-4568.

☆ The Henry J. Kaiser Family Foundation has sponsored a number of surveys and research reports into the knowledge and opinions of teens, parent, and educators, including *Sex Education in America: A View from Inside the Nation's Classrooms.* Call (800) 656-4533 or go to www.kff.org.

Classroom curricula:

☆ CDC's Division of Adolescent and School Health helps educators identify specific curricula with credible evidence of effectiveness in reducing sexual risk behaviors that contribute to HIV infection (CDC does not require their use). For a current list of *Programs that Work* with ordering information go to www.cdc.gov/nccdphp/dash/rtc/hiv-curric.htm. CDC's "Guidelines for effective school health education to prevent the spread of AIDS" (*MMWR* 37(S-2), January 29, 1988) can be downloaded at www.cdc.gov/nccdphp/dash/aids.htm.

☆ *Choosing the Tools: A Review of Selected K–12 Health Education Curricula* is available from the National Training Partnership, a program of the Education Development Center, at (800) 225-4276 or www2.edc.org/NTP.

☆ The National School Boards Association's HIV and AIDS Resource Database contains research, curricula, guidelines, and program descriptions. Call (703) 838-6722 or go to www.nsba.org/schoolhealth.

☆ Advocates for Youth offers on-line fact sheets, issue briefs, lessons plans, resources to support adolescent peer education programs, and programs targeted at specific populations. Call (202) 347-5700 or go to www.advocatesforyouth.org.

☆ The Sexuality Education and Information Council of the United States (SEICUS) offers an annotated bibliography of commercially available HIV/AIDS, sexuality, and abstinence-only curricula at www.siecus.org/pubs/biblio/bibs0010.html, or call (212) 819-9770 to order a hard copy.

☆ The Minnesota Sexuality Education Resource Review Panel reviews sexuality curricula and resources for use in schools. The panel of teachers, public health professionals, health educators, parents, youth, youth workers, and religious leaders completes a written assessment of each resource using a seven-point criteria scale and an assessment of audience appropriateness. View *Sexuality Education Resource Reviews: A Resource Kit for Educators, Parents, and Communities* at www.mnschoolhealth.com/publications/MSERRP.pdf.

☆ State-of-the-art HIV prevention education curricula are available from, among others:

- Central Michigan University Materials Center at (800) 214-8961 or www.emc.cmich.edu/mm
- Comprehensive Health Education Foundation at (206) 824-2907 or www.chef.org/curricl.htm
- Education Development Center at (800) 793-5076 or go to http://notes.edc.org/hhdnotes/products.html
- ETR Associates at (800) 321-4407 or www.etr.org/pub
- National Center for Health Education at (800) 551-3488 or www.nche.org/ghfinalpg/ghhome.html
- National Coalition of Advocates for Students for materials in Spanish, in Haitian Creole, and for Asian students at (617) 357-8507 or www.ncas1.org

☆ www.HealthTeacher.com offers an Internet-based curriculum that is consistent with the national standards and provides lesson guides, assessments, and teacher supports on HIV/AIDS and a broad range of other topics for kindergarten through high school.

☆ The federal Center for Substance Abuse Prevention operates a National Clearinghouse for Alcohol and Drug Information that can provide resource guides and educational materials. Call (800) 729-6686 to speak with a prevention specialist in English; (877) 767-8432 Spanish, (800) 487-4889 TDD, or go to www.health.org.

☆ The American Association for Health Education offers *HIV/AIDS Education for Students with Special Needs: A Guide for Teachers*. Call (800) 213-719 or go to www.aahperd.org/AAHE/programs-hiveducation.html.

Supplemental education programs:

☆ Schools are encouraged to borrow portions of the AIDS Memorial Quilt through the National High School Quilt Program. Call the NAMES Project Foundation at (202) 216-4993 or go to www.aidsquilt.org.

☆ The CDC National STD and AIDS Hotline operates a free "Group Calls" educational activity in which participants have the opportunity to ask HIV/AIDS/STD-related questions. Call (800) 342-AIDS to make arrangements or fill out a form at www.ashastd.org/nah/groupcalls.html.

☆ The National Network for Youth and its member agencies promote the positive development of youth through community service, peer education, alcohol-and drug-free teen clubs, and other ways. For more information or a referral to local agency call (202) 783-7949 or go to www.nn4youth.org.

☆ The National Resource Center for Youth Services offers the *Safe Choices Guide: HIV and other STD Policies and Prevention Program for Youth in High-Risk Situations* for those who work with youth in high-risk situations. Call (918) 585-2986.

☆ The American Red Cross has developed youth-related videos, brochures, workbooks, and other materials. Contact your state or local chapter, which can be located at www.redcross.org.

For parents and families:

☆ The National PTA has a number of materials available for family members, including *How to Talk to Teens and Children About HIV/AIDS* in English and Spanish. Call (800) 307-4782 or go to www.pta.org/programs/hivlibr.htm. Also available is a *Leader's Guide to Parent and Family Involvement*. Some state PTA associations have also developed their own materials.

☆ Talking With Kids About Tough Issues is a national initiative by Children Now and the Kaiser Family Foundation to encourage and support parents to talk with their children earlier and more often about tough issues like sex, HIV/AIDS, violence, alcohol, and drug abuse. Go to www.talkingwithkids.org.

☆ SEICUS offers *How to Talk to Your Children About AIDS* and other parent resources at www.siecus.org/parent/talk/talk0001.html

☆ "Talking to Children about Sexuality and AIDS," an article in *Parent News*, is available from the National Parent Information Network at http://npin.org/pnews/1998/pnew798/featu798.html.

☆ ☆ ☆

Section 7. Related Services

SAMPLE POLICY:

> Students will have access to voluntary, confidential, age and developmentally appropriate counseling about matters related to HIV infection. School administrators will maintain confidential linkage and referral mechanisms to facilitate voluntary student access to appropriate HIV counseling and testing programs, and to other HIV-related services as needed. Public information about resources in the community will be kept available for voluntary student use.

EXPLANATION:

HIV infection can cause serious social and psychological difficulties. Young children and adolescents, whether they have HIV infection or have family members or close friends who are living with HIV, might be worried and scared about the medical effects of the illness or feel anxious about having to keep a confidence. Anxiety, depression, thoughts of suicide, or substance abuse commonly accompany HIV infection among teenagers and adults. But these are not the only people deeply affected: when someone openly discloses infection, in a sense the entire school community is "living with HIV."

Pupil services professionals such as counselors, psychologists, nurses, and social workers should be ready to assist any member of the school community who is troubled about HIV infection. Properly trained and prepared, these staff members can calm fears, address stigmatization, advise teachers, establish support groups, assess needs for age-appropriate individual counseling, and provide referrals to out-of-school services.

HIV counseling and testing

Voluntary HIV counseling and HIV antibody testing are important elements of national efforts to control the epidemic. Seeking a test has several benefits:

- ☆ The experience can be a valuable health education opportunity at a time when a person's full attention is on his or her own behavior.
- ☆ Young people can obtain advice from a counselor about discussing important life issues with their parents.
- ☆ Counselors can refer a person with HIV infection to medical care. Early attention can delay disease progression and help prevent illness. In particular, a woman with HIV infection who is pregnant can greatly

> *The HIV antibody test*
>
> Several laboratory tests can detect the antibodies a person's immune system develops soon after infection with HIV. The terms "HIV-positive" and "HIV-negative" refer to whether or not these antibodies are detected.
>
> *Anonymous* HIV testing centers do not ask for names: no one can trace a person's results. With *confidential* HIV testing, the person's name is known by his or her personal doctor, perhaps a counselor, and, in certain places, the public health department. In many states all HIV testing is confidential in nature.
>
> The tests are highly accurate and reliable when conducted properly. However, a test can sometimes yield an inexact or "false" result if the infection occurred very recently, within the so-called "window period," or because of other rare circumstances.
>
> It is essential that every person seeking the test have thorough counseling by a trained professional to fully understand these details.

HIV counseling for adolescents

Several distinct purposes of HIV counseling are to:

- ☆ provide basic, factual information on HIV and how to prevent its transmission;
- ☆ obtain informed consent before taking a test for HIV antibodies;
- ☆ conduct risk assessment and behavior-change interventions;
- ☆ provide psychological and social support; and
- ☆ assist in accessing needed services and early medical intervention.

Some individuals who engage in high risk practices but receive a negative test result (meaning HIV antibodies were not detected) interpret the results to mean their behavior was not risky after all. Some believe that health educators exaggerate the risk of infection. Thorough counseling by trained staff can dispel such notions.

Not every testing center is prepared to accommodate young people. Adolescent counseling requires specialized training. A counselor cannot simply lecture. To be effective, counseling has to be client-centered, interactive, and tailored to young people's unique behaviors, circumstances, and needs. Counselors must be sensitive to issues of sexuality, sexual identity development, and the cultural context of the client and his or her family. The conversations ought to be in the individual's primary language.

Counselors should neither encourage nor discourage a young person who is seeking an HIV antibody test. Youth need to determine for themselves whether or not to take the test after assessing if their behavior might have put them at risk of infection. Effective HIV counselors help youth consider their situations, support networks, and coping skills by asking such critical questions as:

Why do you want to be tested for HIV?

Have you discussed this with a parent or another adult?

If not, why not?

If the test results are negative, how can you can keep from becoming infected?

If the results are positive, who will you tell?

How will you tell them?

What do you expect your test results to be?

Experts in the education, counseling, and public health fields generally agree that this process should take at least two counseling sessions before an adolescent takes the test. They also recommend more than one post-test session if the result is positive, preferably with the same counselor.

It might be best that a particular adolescent not take the HIV antibody test if high quality counseling is not available. The advantages and disadvantages depend on an individual's maturity, mental and emotional state, risk behaviors, and overall circumstances. Waiting for test results can be tremendously stressful. A positive test result can cause shock, depression, anger, suicidal thoughts, or other intense emotion.

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reduce the chances of her baby being born with the virus if she seeks early treatment.

- ☆ Counselors can advise a person with HIV infection on the ways to prevent further transmission of the virus.
- ☆ A process can begin whereby public health officers notify an infected person's sexual partners of their potential exposure to HIV and encourage the partners to seek counseling and testing.
- ☆ Many people with HIV infection say it is better to know about the infection than to live with uncertainty.

Donating blood

Donating blood is not an appropriate way to be tested for HIV. There are a few things that students should know:

- ☆ The screening process before blood is drawn includes personal questions of a sensitive nature.
- ☆ Notification that a donor should seek further testing usually does not occur in the context of specialized HIV counseling. Such a notice can be traumatic.
- ☆ If infection with HIV occurred recently and the screening test cannot yet identify the presence of antibodies, donating blood could transmit HIV to dozens of other people.

An appropriate school role is to help direct inquiring students to quality HIV counseling and testing services that are adolescent-oriented and certified by state or local health departments. A 1993 survey found that people who had been tested by private providers were substantially less likely to have received counseling (28 percent) than those who obtained tests at a public site (61 percent).[19] A teenager might also miss appropriate counseling if he or she goes to an adult-oriented clinic that is not prepared to accommodate various levels of maturity or can respond to adolescents' unique concerns. Many professionals oppose the use of home test kits on principle because of the inherent lack of face-to-face counseling. Some young people have donated blood to learn their HIV status—theoretically, this could put others in danger.

THE LEGAL CONTEXT:

Most states require parental consent before a counselor can discuss personal issues with a student, unless the situation involves physical or sexual abuse. Some states also exempt substance use problems from consent requirements.

Most jurisdictions legally allow mature and competent adolescents to voluntarily seek HIV antibody testing. Some states require that parents be notified if a minor requests a test, or if a test result is positive for HIV. Other states mandate strict confidentiality.[20] Your local public health department should be familiar with the laws that apply (see Section 1 for a discussion of privacy laws, and Section 4 on "duty-to-warn" statutes.)

IMPLEMENTATION:

Most school districts interpret parental consent laws as requiring permission for a student to see a counselor about *anything*, not permission to address specific topics. Nevertheless, close family involvement is almost always desirable: most pupil services personnel are trained to facilitate communication between students and their parents. Schools can take a proactive lead at raising important mental health issues among parent groups, and can actively encourage parental consent for counseling services at the beginning of the school year.

Schools should not attempt to conduct or sponsor a HIV antibody testing program themselves. Instead, schools can do several things to help students voluntarily access HIV testing and counseling services that are "adolescent-friendly":

> *Testing cannot replace education*
>
> "Current research indicates that the AIDS virus may be 100 to 1,000 times more infectious during the first two month of infection, when routine HIV antibody tests are [not always able] to tell whether people are infected."
>
> *HIV/AIDS Treatment Information Service*

- ☆ Counseling offices and libraries can leave public domain resource guides that list HIV counseling, testing and other services in places where students can privately search for information at their own initiative.
- ☆ Pupil services professionals can develop a confidential referral network of appropriate adolescent-oriented HIV counseling and testing programs in order to help students who are voluntarily seeking the services.
- ☆ Pupil services staff members can actively coordinate with HIV counseling and testing programs so that, for example, a testing site is a welcoming place for teens; an adult always accompanies a student to an appointment (many experts consider this essential); and students are reminded to return for counseling appointments or test results. Often, fewer than half the adolescents tested at a particular site return to obtain their results.
- ☆ In areas hardest hit by the HIV epidemic, school administrators might want their pupil services staff members formally trained in adolescent HIV counseling. Many local and state health departments offer training programs they can attend.
- ☆ If quality can be ensured, a school-linked health clinic might be able to add HIV antibody testing to its menu of health services.

What should a school do if someone dies?

If a student or staff member dies, from whatever cause, a school administrator should disseminate the news of the death as soon as possible. Students should be told by someone they know and trust, ideally in small groups, not impersonally over the public address system. To dispel rumors, the person reporting should briefly describe the cause of death, answer questions (taking care not to violate the family's privacy), and allow expressions of grief. Letters to parents should be sent home that include information on normal and natural responses to death. Include warning signs of unhealthy reactions, such as extended depression or obsessive thoughts about death.

School administrators should generously allow for and actively support student-generated memorial ceremonies, rituals, and activities. However, the normal school routine needs to be returned to as soon as possible to assure students of security and stability.

A student's or a school staff member's performance is likely to be affected for several weeks following the death of a loved one. A support group can help by offering a comfortable setting for people to express emotion. A person having serious trouble dealing with a loss might need referral to bereavement or other mental health services, or might benefit from the guidance and support of a spiritual leader.

The debate on condom availability programs

The debate over school-based condom availability programs is intense in many communities. Such programs give rise to much discussion about how best to prevent HIV infection among teenagers who are sexually active.

The Centers for Disease Control and Prevention have determined that, "For those who are sexually active, latex condoms are highly effective when used consistently and correctly... [Condoms] are an effective barrier to viruses, including HIV and the much-smaller hepatitis B virus."[21] As part of an overall HIV prevention plan, some schools have therefore decided to make latex condoms available to students who request them.

Supporters argue that student condom availability programs will decrease the number of teens who engage in unprotected sex—teens who are putting themselves at risk of various sexually transmitted diseases and unwanted pregnancy as well as HIV infection.

Others are concerned that making condoms available sends the wrong message to young people—that the school, in effect, condones sexual behavior. Many are convinced that talking about sex and/or making condoms available encourages teenagers to experiment.

The debate involves a basic issue: the role of the school in promoting healthy conduct. Many people argue that schools should stick to academics and this kind of program is not and should not be the schools' responsibility. Some insist that such sensitive issues should be dealt with by parents. Others retort that parents and families need help in providing such information to their children, and that schools are in the best position to supplement parental guidance.

The Massachusetts Board of Education resolved in 1991:

> *"We recommend that every school committee [local school board], in consultation with superintendents, administrators, faculty, parents and students consider making condoms available in their secondary schools... We recommend that school districts consider whether students at the secondary level need instruction about the correct use of condoms in order to increase understanding and effect behavior change. Finally, we recommend that parent information accompany any efforts to make condoms available to students in schools. Parents would then be able to reinforce AIDS/HIV prevention messages at home, and place these messages in the context of their own personal values and religious traditions."*

If a school decides to establish a condom availability program, the effort should be just one aspect of a multi-faceted HIV prevention strategy.

RESOURCES:

General counseling:

☆ In addition to the information sources cited earlier in this guide, another is the National Teenage AIDS Hotline at (800) 440-TEEN and a number of websites designed for adolescents, including:
www.iwannaknow.org
www.youthhiv.org
www.ZapHealth.com
www.Teenwire.com
www.TeenAIDS.org
www.itsyoursexlife.com
www.goaskalice.columbia.edu
www.sxetc.org

☆ The National Youth Crisis Hotline provides immediate counseling and referrals to local services. Call (800) 448-4663.

☆ The Teen Crisis Hotline automatically connects callers to their closest crisis center. Call (800) 784-2433.

☆ Most local AIDS services organizations can provide counseling on living with the presence of HIV infection. To find a local organization call the National Association of People with AIDS at (202) 898-0414.

☆ Several pupil services professionals' membership organizations have resources on counseling, grief, and crisis intervention and planning including the American School Counselor Association at www.schoolcounselor.org.

☆ The National Mental Health Association provides free information on mental health topics, such as bereavement and warning signs of mental illness, and makes referrals to mental health providers. Call (800) 969-6642, go to www.nmha.org, or e-mail to nhainfo@aol.com.

☆ Many local hospices, mental health clinics, health departments and hospitals offer training on a variety of topics, and often provide direct and indirect assistance with counseling.

☆ The Measurement Group operates an Evaluation and Dissemination Center to share lessons learned from 10 national demonstration projects called *Innovative Models of Adolescent HIV/AIDS Care*. Go to http://tmg-web.com/adolspns.htm.

HIV counseling and testing:

☆ Local HIV antibody testing sites can be found in the phone book. These are usually public health or community-based clinics. Most physicians and clinics can also arrange for a confidential HIV antibody test on request.

☆ CDC's Division of HIV/AIDS Prevention offers complete information and guidance on HIV testing and counseling programs. Go to www.cdc.gov/hiv/testing.htm.

☆ HIV InSite, operated by the University of California at San Francisco, contains numerous articles, position papers, research studies, and other resources concerning adolescent HIV testing and counseling. Go to http://hivinsite.ucsf.edu/InSite.jsp.

☆ The Center for Adolescent Health and the Law works to create a legal and policy environment that promotes the health of adolescents and their access to health care. To obtain information or to request assistance call (919) 968-8870, send an e-mail to info@adolescenthealthlaw.org, or go to www.adolescenthealthlaw.org.

Condom availability programs

☆ A four-page fact sheet on *Condoms and Their Use in Preventing HIV Infection and Other STDs* is available from CDC at www.cdc.gov/hiv/pubs/facts/condoms.pdf.

☆ Condom availability program guides are available from Advocates for Youth at (202) 347-5700 or go to www.advocatesforyouth.org.

☆ The Academy for Educational Development offers *Protecting Youth, Preventing AIDS: A Guide For Effective High School HIV Prevention Programs*, which contains lessons learned from New York City's experience with condom availability programs. Call (212) 367-4568.

☆ The Henry J. Kaiser Family Foundation has published several reports concerning condom availability programs. Call (800) 656-4533 or go to www.kff.org.

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☆ ☆ ☆

Section 8. Staff Development

SAMPLE POLICY:

> All school staff members will participate in a planned HIV education program that conveys factual and current information; provides guidance on infection control procedures; informs about current law and state, district, and school policies concerning HIV; assists staff to maintain productive parent and community relations; and includes annual review sessions. Certain employees will also receive additional specialized training as appropriate to their positions and responsibilities.

IMPLEMENTATION:

School staff members need training and basic information to prepare to deal with HIV infection. The needs are not extensive: administrators can sponsor dedicated workshops or integrate essential HIV-related topics into first aid trainings, back-to-school orientations, or staff briefings. Schools should conduct periodic review sessions. Employee handbooks could summarize HIV-related policies and procedures. New employees should participate in a training program within a reasonable time after beginning work.

Infection control procedures are best taught through demonstration by qualified professionals with hands-on practice. Distributing written materials is not adequate, especially for staff members who have difficulty reading or understanding English. Hands-on practice allows evaluation of an employee's true understanding.

Specialized Training

Teachers assigned to HIV prevention education need a sound knowledge base, orientation to an appropriate curriculum, teaching skills that match instructional objectives, and an ability to sensitively address controversial topics. Some also need opportunities to discuss personal concerns that might inhibit or influence their ability to teach effectively. Following initial training, classroom-based evaluation and personal mentoring can prove valuable.

Administrators and other teachers should be familiar with HIV prevention education goals even if they are not expected to teach it.

Coaches and **athletic trainers** are important role models, set standards for many students' behavior, and often serve as unofficial counselors. It is essential that they be familiar with risk factors for HIV infection and know how to guide youth towards health.

Pupil services personnel should receive formal training in crisis management. Topics

> CALIFORNIA:
> In-service training
>
> County offices of education and school districts, through regional planning, joint powers agreements, or contract services, shall cooperatively plan and conduct in-service training to all teachers and school employees who provide AIDS prevention instruction. This in-service training shall be conducted periodically to enable staff to remain current with new developments in the scientific understanding of AIDS as well as with new prevention education techniques...
>
> It is the intent of the Legislature that, to the extent possible, training be provided to a team of educators and parents, including school board members, administrators, teachers, parents, classified personnel, and counselors.
>
> *1991*

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might include bereavement counseling, which involves a specialized set of knowledge and skills, and helping troubled students and staff members through other critical situations such as serious illnesses, accidents, and natural disasters.

In addition, pre-practice and professional development programs for pupil services personnel should include basic information about HIV counseling.

Staff development topics

	Board members	Adminis -trators	Teachers	Coaches, Trainers	Pupil services staff*	Special educ. staff	Office staff	Main tenance staff	Bus drivers
Facts about HIV and AIDS	☆	☆	☆	☆	☆	☆	☆	☆	☆
Infection control guidelines	☆	☆	☆	☆	☆	☆	☆	☆	☆
Rights of those with HIV/AIDS	☆	☆	☆	☆	☆	☆	☆	☆	☆
Privacy protections	☆	☆	☆	☆	☆	☆	☆	☆	☆
Handling disclosure		☆	☆	☆	☆	☆	☆	☆	☆
Employment policies	☆	☆	☆	☆	☆	☆	☆	☆	☆
Parent involvement	☆	☆	☆	☆	☆	☆	☆		
Talking to the media	☆	☆	☆	☆	☆	☆	☆	☆	☆
Federal and state laws	☆	☆			☆	☆			
Medical record keeping		☆		☆	☆	☆	☆		
Cross-agency collaboration		☆	☆	☆	☆	☆			
HIV-related health problems		☆			☆	☆			
Effective HIV education	☆	☆	☆	☆	☆	☆			
HIV counseling and testing					☆				
Crisis and grief counseling					☆				

*Includes school nurses, counselors, social workers, and school psychologists

RESOURCES:

- ☆ Most state departments of education sponsor staff development opportunities through a variety of offices. For example, transportation offices are often valuable resources and potential training providers for school bus drivers.
- ☆ American Red Cross chapters, hospitals, and other community-based organizations are frequently good sources of staff development assistance.
- ☆ *HIV Prevention for Teachers of Elementary Education and Middle School Grades, HIV/AIDS Education for Students With Special Needs,* and other materials are available from the Association for the Advancement of Health Education at (703) 476-3400 or go to www.aahperd.org/aahe.
- ☆ The *Handbook for Evaluating HIV Education*, available from the CDC Division of Adolescent and School Health, includes a section on staff development. Call (888) 231-6405 or go to www.cdc.gov/nccdphp/dash/evaluation_manuals/hiv.htm.
- ☆ The National Training Partnership, managed by Education Development Center and supported by CDC's Division of Adolescent and School Health, assists state and local education agencies to strengthen their capacity to implement trainings that will improve health education and HIV prevention provided in schools and other youth-serving organizations. For information and extensive training resources visit their website at www2.edc.org/NTP or call (800) 225-4276.
- ☆ The American Association of Colleges for Teacher Education offers a CD-ROM curriculum tool for teaching HIV/AIDS prevention to pre-service teachers called *Everything You Wanted to Know about HIV/AIDS in the Classroom, but Were Afraid to Ask: A Teacher's Interactive Journey.* Call (202) 293-2450 or e-mail to lbozeman@aacte.org.

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☆ ☆ ☆

Section 9. General Provisions

SAMPLE POLICY:

> On an annual basis, school administrators will notify students, their family members, and school personnel about current policies concerning HIV infection and provide convenient opportunities to discuss them. Information will be provided in major primary languages of students' families.
>
> This policy is effective immediately upon adoption. In accordance with the established policy review process, or at least every three years, *designate* shall report on the accuracy, relevance, and effectiveness of this policy and, when appropriate, provide recommendations for improving and/or updating the policy.

EXPLANATION:

Family communication and outreach, critical to the mission of education, should be explicitly included within an HIV infection policy. Parents should have opportunities to raise concerns with school leaders and have their issues addressed.

In order to keep up with constantly changing information and legal parameters, policymakers should build in requirements to periodically evaluate a policy's effectiveness and pertinence.

IMPLEMENTATION:

There are several ways to disseminate information about a state's, district's or school's policies. An administrator can submit them to the local newspaper, print the policies in the school handbook, or review them in back-to-school assemblies held at the beginning of the school year. The best ways to do it will differ for each community.

Regardless, all communications with parents and families need to be in a form and language they can best understand.

RESOURCES:

- ☆ The *Handbook for Evaluating HIV Education*, available from the CDC Division of Adolescent and School Health includes a section on policy evaluation. Call (888) 231-6405 or go to www.cdc.gov/nccdphp/dash/evaluation_manuals/hiv.htm.
- ☆ The Montana Office of Public Instruction has an HIV policy evaluation guide entitled *Developing and Revising HIV Policies* that contains checklists and an end-user questionnaire. Call (406) 444-3680 or to www.metnet.state.mt.us/HealthEnhancement/Curricula-Publications/%233751366.

MISSOURI: Updating Policies

"The continuing expansion of medical knowledge about chronic infectious diseases such as AIDS, hepatitis and herpes, and expanding statutory and case law on the rights of individuals who may have the diseases, make it imperative that local boards of education routinely review their policies and procedures for dealing with communicable diseases to be sure they are both legal and effective. The State Board of Education reviews its policy guidance to school districts periodically to incorporate the latest information… [and] recommends that all local boards of education review their policies and procedures and make adjustments where necessary."

Policy Guidance on Communicable Diseases, 1995.

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Chapter III: ENGAGING THE COMMUNITY

Communication and dialogue are the keys to effective policy implementation. A broad-based foundation of community support is also the best insurance against disruptive conflict that can distract a school from its educational mission.

Schools and school districts often succeed at implementing HIV-related policies without controversy by implementing proactive communications strategies, and by educating the community as necessary. At the same time, prudent administrators also prepare for a potential public relations crisis by developing a controversy management plan. Crises *are* frequently averted, even if success stories rarely make the headlines.

A PROACTIVE COMMUNICATIONS PLAN:

School leaders should disseminate information about HIV-related policies soon after they are adopted. Publicizing policies can strengthen the perception that school authorities are competently addressing difficult issues.

If your public information officer already has a communications plan for the agency, incorporate HIV-related policy issues into it. If no communications plan currently exists, it would be wise to prepare one for this policy initiative.

An important task is to identify several brief and simple messages that make sense to the public. Community concerns about HIV and schools typically focus on the safety of non-infected children. Appropriate messages might therefore highlight the mandatory use of infection control guidelines in schools, interagency collaboration for HIV counseling and testing services, and the teaching of effective HIV prevention education to all school children. If community members are particularly concerned about the content of instructional materials, an appropriate message might highlight the materials selection criteria and review process.

At the state level, public opinion research can help to clarify what the public's priority concerns are. State level administrators need to pay special attention to the concerns of legislators, key executive branch staff members, and business leaders.

Administrators can employ a variety of techniques to publicize and build support for newly adopted or revised HIV-related policies. One of the most important is to assist the community representatives who were involved in the policy development process to explain the policies to their constituents. The community representatives are the best judges of what they need to best communicate with their constituents: talking points, brochures, or perhaps the attendance of medical or legal experts at a series of meetings. It might be necessary to

Talking things through

"Compassion doesn't come naturally, the social scientists say, but develops through practice and social learning. This is what transpired in the open forums on AIDS, as people changed their minds after talking things through in sessions shaped and informed by exemplary leaders... Sentiments are often transformed by... conversations with neighbors and school chiefs and experts..."

David Kirp in *Learning by Heart: AIDS and Schoolchildren in America's Communities*[22]

develop sub-plans that address the circumstances or communications patterns of particular groups.

A good communications plan is not a one-way flow of information. Rather, it attempts to engage and be responsive to the public. Community members must have opportunities to express their concerns and feel they are being sincerely listened to.

Another valuable communications strategy is to cultivate effective working relationships with local media representatives. School officials can invite reporters, talk show hosts, and TV news producers to demonstrations of exemplary school initiatives, news conferences, and key public hearings. Print, video, or audiotape interviews or submitted guest commentaries help to inform the public. Proactive school officials find the time to brief—and educate—media representatives about HIV and related state, district, and school policies. Helping news organizations understand the value of confidentiality is especially important, because if controversy emerges the reporters will better understand in advance the "ground rules" the education system must follow.

Some state departments of education sponsor communications training workshops across their states. State HIV/AIDS education coordinators should stand ready to provide technical assistance upon request.

EDUCATING THE COMMUNITY:

Education leaders might find that many local people are fearful or misinformed about HIV infection. Strong emotions often underlie public discussions of HIV infection, even if they are not openly expressed. A community education program might be necessary to dispel myths, correct misunderstandings, or address people's worries.

A community education program must be responsive to its audience's particular concerns if it is to accomplish its goals. The

Community planning for HIV prevention

"Community planning," a process that all state departments of health must conduct, is a natural vehicle for cross-agency collaboration between schools and public health agencies.

HIV Prevention Community Planning Groups oversee federal funds provided through CDC for health education, risk reduction, counseling, testing, minority initiatives, and outreach to substance users. The groups develop prevention plans to respond to high priority, community-validated needs of populations most affected by HIV. Many states have extended the process to regional and local levels.

If the opportunity exists, educators should actively participate in the process in order to coordinate different agencies' prevention efforts. Youth are more likely to find consistent messages credible, and consistency helps to reinforce risk-avoiding behavior. The community perspective and feedback gained through the process can help to assess and improve school-based programs and to strengthen public support.

Youth's concerns and realities can easily be overlooked in the inherently political community planning process. Many adults believe that youth at highest risk for HIV infection are not in school. Educators know, however, that many youth who practice high-risk behaviors *do* attend school, or "drop-out" and "drop-in" repeatedly. A coordinated strategy can build a continuum of education and prevention interventions for youth across all settings in which they live and interact.

CDC recommends that education departments be involved in the process, but this is not a requirement. But whether or not school officials actively participate, the process can directly affect school-based prevention efforts. Interested board members and other educators should call the AIDS Program Director within the state or local health department for more information about appointment procedures.

person planning the program should ask a sampling of people what they feel about the education system's HIV-related policies and if there is anything they want to know about HIV or the policies. Key informants can provide clues about the needs, interests, views, beliefs, and taboos of a particular community. Local organizations that work closely with the community might be willing to help develop appropriate education strategies. In most places, public health departments and other community-based AIDS services organizations conduct ongoing HIV/AIDS education programs. Officials in these organizations might be happy to collaborate.

Some people believe that HIV was intentionally created and spread.

The more relevant issue is that people can avoid HIV infection.

To the extent possible, some people from the intended audience should be involved in planning an education program so that the approaches, terminology, pacing, and examples used make good sense to the audience. Facts should be clearly presented so that people understand the low risk of HIV transmission at school. Conquering fear takes time. An educator should not assume how well anyone knows or understands HIV infection: a person's title, profession, or level of education implies nothing. Addressing anonymously submitted questions from the audience is one technique for finding out what is on people's minds.

Presenters must be credible and trusted by those they are addressing. A medical authority who is knowledgeable about HIV is usually helpful. Testimony by a person living with HIV infection often has a powerful impact: "putting a face on the epidemic" can help to strengthen compassion and lessen fear.

People who want to be involved in HIV prevention can, among other things, volunteer for World AIDS Day (December 1), help educate the community, or join service programs that provide direct assistance to people with HIV infection.

The need for community education can arise very suddenly, such as when HIV-related policies are adopted or reviewed, when it becomes known that a well-known celebrity has HIV infection or AIDS, or when outside organizations spread misinformation. Districts and schools should prepare in advance and always stay ready by keeping supplies of printed materials on HIV and AIDS on hand, plus numerous copies of infection control guidelines and operative policies. Also, maintain a list of possible speakers.

CRISIS MANAGEMENT PLAN:

Every education agency should have a controversy management plan that outlines how to deal with a sudden public relations crisis. Such a plan might prove useful in all kinds of situations that do not involve HIV infection. Suggested elements include:

☆ *Establish and disseminate policies and procedures regarding news media contacts.* Policies concerning the presence of reporters inside schools or on school property help to prevent education employees or students being randomly targeted to express their personal opinions, which might not agree with official positions. Policies should identify the person to whom school staff members should always refer reporters, and establish procedures for allowing media access to students, e.g., requiring parental permission.

☆ *Determine who will be in charge during a crisis.* Every school official should know who is responsible for managing a public relations problem. If more than one

person has key duties, the major actors must clearly understand each others' roles. The best crisis managers might not be the most senior people: normal procedures and lines of authority can prove too slow to keep ahead of fast-moving events.

☆ *Appoint a single, effective spokesperson.* A board member or top school official should publicly represent the school or district during a crisis. This must be a person who is able to speak to the public and the news media in a calm, well-informed, and sensitive manner. This person might require training or other special preparation.

☆ *Identify influential supporters.* Establish and occasionally update a list of prominent public officials, clergy members, business leaders, physicians, public health experts, or other community leaders who can be counted on to endorse the school's policies. Testimony from articulate students, or from representatives of youth-serving organizations or AIDS services agencies, can be useful. Each individual needs to understand in advance his or her expected role.

School decision makers should also consider whether their established public meeting rules and procedures are enough to preserve order when emotions run high. Rules should encourage expression of different perspectives on an issue, but not allow organized groups to dominate the microphone. Many school districts:

☆ Designate a fixed period of time for the entire discussion, which can extend over more than one hearing.

☆ Enforce strict time limits for speakers' presentations.

☆ Require that speakers state the school and grade their children attend.

☆ Require that people wanting to speak sign in first, and then randomize the order of speakers to prevent pre-scripted relay presentations.

The purpose of a hearing is generally to gather input, not to debate. School board members should resist pressures to make immediate decisions during a hearing unless absolutely necessary. Differences in opinion must be respected, but personal insults do not belong in public discourse and do not have to be tolerated.

Rules governing the conduct of speakers can help to defuse controversy—but only if adopted *before* the need arises. Frantically establishing guidelines while a crisis is happening could generate resentment and hostility. When the time comes, whatever meeting policies are already in place must be followed to avoid perceptions of unfairness, arrogance, or manipulation.

State officials can form "rapid response teams" to help district and school authorities in dealing with public relations problems, drawing on advice from the agency's public information officer or another public relations expert. State officials should be prepared to share the names of superintendents and administrators who have successfully resolved HIV-related controversies in their communities.

DURING A CRISIS...

Even if school policymakers have adopted a sound set of policies and made efforts to educate the public, and the local media are generally supportive, a day might arrive when the presence of a student or staff member with HIV infection causes some community members alarm. A negative situation with sensational media attention can grow virtually overnight.

If controversy suddenly emerges, follow the controversy management plan that was prepared in advance. Keep in mind the following points:

☆ *Find the truth and prepare several talking points.* The spokesperson must understand the facts of the current situation so that all the information released is accurate and honest. Prepare a concise question-and-answer sheet. Effective spokespersons mostly confine their comments to a few, brief, well-rehearsed points that the public can readily comprehend. These points should be consistently repeated when talking with any media representative, whether on or off the record.

☆ *Act with confidence.* Even if the situation is fluid and confusing, leaders must convey their effective management of the situation by what they say and do. Stay accessible, calm, open, and positive in tone, not defensive. Promptly admit mistakes. Saying little is better than saying nothing. Explaining why nothing can be said is better than stonewalling.

☆ *Mobilize influential supporters.* Contact the community leaders who are known to be sympathetic with school policies and ask their help in reassuring their constituencies and/or talking with the media.

☆ *Remind education personnel who is in charge and who will speak to the media.* Consistency of messages is essential. All staff members need to understand that the appointed spokesperson is the *only* person allowed to respond to media inquiries.

☆ *Conduct as many public meetings as necessary.* School and public health officials, as well as community leaders, should proactively participate in community forums to present the facts and explain the rationale for new or revised policies. People in the audience should have their questions answered by credible health professionals who are knowledgeable about HIV. Students should have their say. Experience teaches that time devoted to public meetings generally results in gradually increasing levels of support.

☆ *Consult with experienced others.* Contact the state department of education or health for advice about the situation and further referrals. Superintendents and administrators who have already resolved HIV-related conflicts in their communities are particularly useful resources because they can share practical tactics for settling a crisis. Contact the sources listed in this guide.

"Crisis" can also be "opportunity." Many communities find that a crisis can be exhausting and painful for some, but can also result in increased parent and community support.

Should school leaders reveal that someone has HIV infection?

No. Announcing that a student or a school staff member has HIV infection will likely torment that person and his or her family. An announcement without permission would violate Federal law (see Section 3), and in any event would not increase anyone's level of safety. Even if a school administrator holds back the person's name and simply announces that *someone* in the school has HIV infection, chances are that the person's confidentiality will be violated eventually. Meanwhile, speculation and rumor will distract students and staff members from the school's mission.

Instead of announcing that someone with HIV infection is in school, the principal should launch an initiative to implement infection control guidelines. The fact that every county in the United States has cases of AIDS should be reason enough to publicly justify such an initiative at any time.

Even if there is some public knowledge about a case of HIV infection, school officials should never disclose any information about the person's identity, location, age or grade level, extent of illness, or even gender. If a school employee is directly asked to verify a rumor that someone in the school has HIV infection, the answer should be non-committal, such as, "Even if I knew whether someone is, I could not say." Then cite the district's or school's policies about confidentiality.

Such a query presents a good opportunity to remind the questioner that *anyone* could have HIV infection and that staff members are consistently following infection control guidelines. A confident attitude can calm others: "We assume that anyone might have HIV infection, but we're not worried about it. We're doing what's necessary to prevent HIV transmission."

What if a family <u>wants</u> to go public?

A person or family may wish to openly reveal HIV infection for a variety of reasons. When done well, public disclosure can result in a positive outpouring of support.

A staff member who knows about someone's intention to disclose HIV infection to others at school should urge the person to first discuss it with the principal. Administrators can then prepare a systematic plan for the announcement at an appropriate time and place. Such a plan might include a staff meeting to discuss the implications for the school, letters to parents, and a series of community education sessions.

An HIV/AIDS education specialist at the state department of education might be able to provide the name of another school or district in the area that has successfully handled public disclosure of HIV infection.

Baseball, Hotdogs, Apple Pie, and HIV

POZ Magazine, 12/95–1/96

Henry [deleted] is a 22-year-old hemophiliac who was infected with HIV at age 10. He and his family kept his condition a secret until Henry was 17, at which time he held a press conference and decided to tell his story as a community project towards becoming an Eagle Scout. Henry notes that until that time in 1991, he lived in fear of being exposed and rejected. "For so many years we had been hiding it. [We] had been biting our tongues, and [were] paranoid because we were afraid someone would find out," he says. For the second portion of Henry's Eagle Scout project, Henry visited schools and met with children to teach them about AIDS in a nonjudgmental way.

RESOURCES:

Communications:

- ☆ The National School Public Relations Association can offer assistance and advice on communications planning: call (301) 519-0496. Their website at www.nspra.org offers several resources including a tutorial on *Starting a School Public Relations Program.*
- ☆ The National School Boards Association and many state school boards associations have sample or model policies on media relations, community relations, and conduct of public meetings. Call (703) 838-6722 or go to www.nsba.org/schoolhealth.
- ☆ The American School Health Association offers *A Comprehensive Approach to Reduce Pregnancy and the Spread of HIV: An Advocacy Kit,* and *Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations.* Call (216) 678-1601 or go to www.ashaweb.org.
- ☆ The Vermont Department of Education offers *Preparing Communities for HIV+ Children: Turning Fear into Knowledge and Compassion.* Call (802) 254-4511.
- ☆ Advocates for Youth offers an *Advocacy Kit* that provides in-depth information on building coalitions, conducting needs assessments, planning public education campaigns, working with the media, educating policymakers and responding to opposition. Call (202) 347-5700 or go to www.advocatesforyouth.org/publications/catalog.htm.
- ☆ The Education Commission of the States offers *Building Community Support for Schools: A Practical Guide to Strategic Communications.* Call (303) 299-3692 or go to www.ecs.org.
- ☆ The Sexuality Information and Education Council of the U.S. (SIECUS) offers an on-line *Community Action Kit* at www.siecus.org/advocacy/kits0000.html, or call (212) 819-9770 to order.
- ☆ *Building Business Support for School Health Programs: An Action Guide* from the National Association of State Boards of Education provides detailed, step-by-step guidance on how to encourage state and local businesses to support school health efforts. Call (800) 220-5183 or go to www.nasbe.org/healthyschools.
- ☆ The Prevention Marketing Initiative of CDC has information on "Managing Issues" at www.cdc.gov/hiv/projects/pmi/issue.htm.
- ☆ *Point-Counterpoint: An Action Plan for Dissent and Debate* identifies some of the tactics that dissenters use to advance their goals and approaches that can help to keep meeting objectives in focus. Go to www.pta.org/programs/edulibr/pointcp.htm or call the National PTA at (800) 307-4782.
- ☆ *How to Deal with Community Criticism of School Change* is available from the Association for Supervision and Curriculum Development at (800) 933-2723 or http://shop.ascd.org.

Educating the community:

- ☆ The American Red Cross offers national instructional programs designed for different audiences, including African Americans and Latinos. View descriptions of these programs at www.redcross.org.
- ☆ The CDC National Prevention Information Network offers many culturally-specific publications and links to organizations that work with different communities at www.cdcnpin.org or call (800) 458-5231 for personal assistance.
- ☆ The Office of Minority Health Resource Center serves as a national resource and referral service on minority health issues, offering customized database searches, publications, mailing lists, and referrals regarding American Indian and Alaska Native, African American, Asian American and Pacific Islander, and Hispanic populations. Go to www.omhrc.gov, call (800) 444-6472, or e-mail to info@omhrc.gov.
- ☆ The U.S. Surgeon General's *Leadership Campaign on AIDS* aims to galvanize minority community leader involvement and work in partnership with minority communities to increase HIV/AIDS knowledge, awareness, and action. Go to www.surgeongeneral.gov/aids/tlcapage1.html.
- ☆ The National Minority AIDS Council works to develop local leadership within communities of color. For more information call (202) 483-6622, go to www.nmac.org, or e-mail info@nmac.org.
- ☆ The African American AIDS Policy and Training Institute provides community-based training and policy support. Go to www.blackaids.org or call (213) 353-3610.
- ☆ Local AIDS services organizations might be able to arrange for a person living with HIV infection to participate in a school or community education session.

- ☆ The National Association of People with AIDS maintains a database of adults and youth who serve as speakers and conduct educational forums. Call (202) 898-0414 or go to www.napwa.org.
- ☆ Information kits about World AIDS Day are available from the American Association for World Health at www.aawhworldhealth.org or call (202) 466-5883.

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References

[1] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report: U.S. HIV and AIDS cases reported through June 2000, Midyear edition,* Volume 12, Number 1.

[2] Centers for Disease Control and Prevention, *Status of Perinatal HIV Prevention: U.S. Declines Continue,* Fact Sheet, CDC-NCHSTP-Division of HIV/AIDS Prevention, November 1999.

[3] Centers for Disease Control and Prevention, *HIV/AIDS Among African Americans,* Fact Sheet, CDC-NCHSTP-Division of HIV/AIDS Prevention, November 14, 2000.

[4] *American Red Cross Facts Book,* 1994.

[5] Special Initiative on AIDS, *Casual Contact and the Risk of HIV Infection,* American Public Health Association, second edition, July 1989.

[6] Centers for Disease Control and Prevention, "HIV transmission between two adolescent brothers with hemophilia," *Morbidity and Mortality Weekly Report,* December 14, 1993, Vol. 42, No. 49, p. 948-51.

[7] Agency for Health Care Policy and Research, "Costs decline for treating HIV-infected children," *AHCPR Research Activities,* July/August 1995, vol. 186, p. 10.

[8] Twomey, J.G., and Fletcher, J.C., "Ethical issues surrounding care of HIV-infected children," in Pizzo, P.A., and Wilfert, C.W., eds., *Pediatric AIDS: The Challenge of HIV Infection in Infants, Children and Adolescents,* 2nd ed., 1994, Williams & Wilkins: Baltimore, p. 713-24.

[9] Conversation with infectious control specialist at CDC, May 13, 1995.

[10] CDC National AIDS Clearinghouse, "Locating information about HIV/AIDS and sports," 1995.

[11] Baldo, M., Aggleton, P., Slutkin, G., "Does sex education lead to earlier or increased sexual activity in youth?" WHO Global Programme on AIDS, Geneva, Switzerland, May 27, 1993. Evidence is also presented in the Kirby *et al.,* article below.

[12] Kirby, D. *et al.*, "School-based programs to reduce sexual risk behaviors: A review of effectiveness," *Public Health Reports,* May–June 1994, 109:3, p.339–60. This paper is expanded upon in *Sex Education in the Schools,* a 1994 monograph published by the Henry J. Kaiser Family Foundation.

[13] Coker, A. *et al.*, "Correlates and consequences of early initiation of sexual intercourse," *Journal of School Health,* November 1994, Vol. 64, No. 9, p. 372–77.

[14] Holtzman, D. et al., "Trends in risk behaviors for HIV infection among U.S. high school students, 1989–91," *AIDS Education and Prevention,* 1995; 7:265–77. Cited in Advocates for Youth, "Parent-child communication: Promoting healthy youth," factsheet, September 1995.

[15] Schoenborn, C.A., *et al.*, "AIDS knowledge and attitudes for 1992: Data from the National Health Interview Survey," *Advance Data,* 1994; #243:1–9. Cited in Advocates for Youth, "Parent-child communication: Promoting healthy youth," factsheet, September 1995.

[16] Shoop, D.M. & Davidson, P.M., "AIDS and adolescents: the relation of parent and partner communication to adolescent condom use," *Journal of Adolescence,* 1994; 17:137–48. Cited in Advocates for Youth, "Parent-child communication: Promoting healthy youth," factsheet, Sept. 1995.

[17] Wooley, S., "Behavior mapping: A tool for identifying priorities for health education curricula and instruction," *Journal of Health Education,* 6:4, July/August 1995, p. 200–6.

[18] Kerr, D., Allensworth, D., Gayle, J., *School-Based HIV Prevention: A Multi-Disciplinary Approach,* Kent, Ohio: American School Health Association, 1991.

[19] Centers for Disease Control and Prevention, "HIV Counseling and Testing—United States, 1993," *Morbidity and Mortality Weekly Report,* March 10, 1995, Vol. 44, No. 9.

[20] English, A., "Expanding access to HIV services for adolescents: Legal and ethical issues." In *Adolescents and AIDS: A generation in jeopardy.* R.J. DiClemente, editor, Newbury Park, CA: Sage, 1992, p. 262–83.

[21] Centers for Disease Control and Prevention, "Update: Barrier protection against HIV infection and other sexually transmitted diseases," *Morbidity and Mortality Weekly Report,* August 6, 1993, Vol.42, No. 30.

[22] Kirp, D. *et al.*, *Learning by Heart: AIDS and Schoolchildren in America's Communities,* 1989, New Brunswick, NJ: Rutgers University Press, p. 282.

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Appendix A: SELECTED RESOURCES

Advocates for Youth
1025 Vermont Avenue NW, Suite 200
Washington, DC 20005
Phone: (202) 347-5700
Fax: (202) 347-2263
E-mail: info@advocatesforyouth.org
Internet: www.advocatesforyouth.org

African American AIDS Policy and Training Institute
1833 W. 8th. Street, Suite 211
Los Angeles, CA 90057
Phone: (213) 353-3610
Fax: (213) 989-0181
E-mail: info@aaainstitute.org
Internet: www.aaainstitute.org

AIDS Alliance for Children, Youth and Families
1600 K Street, NW, Suite 300
Washington, DC 20006
Phone: (202) 785-3564
Fax: (202) 785-3579
E-mail: info@aids-alliance.org
Internet: www.aids-alliance.org

American Academy of Pediatrics (AAP)
141 Northwest Point Boulevard
Elk Grove Village, IL 60007
Phone: (847) 434-4000
Fax: (847) 434-8000
Internet: www.aap.org

American Association for Health Education
1900 Association Drive
Reston, VA 20191-1599
Phone: (800) 213-7193
Fax: (703) 476-6638
E-mail: aahe@aahperd.org
Internet: www.aahperd.org/aahe

American Association for World Health (AAWH)
1825 K Street, NW, Suite 1208
Washington, DC 20006
Phone: (202) 466-5883
Fax: (202) 466-5896
E-mail: staff@aawhworldhealth.org
Internet: www.aawhworldhealth.org

American Bar Association (ABA)
AIDS Coordination Project
740 15th Street, N.W.
Washington, D.C. 20005
Phone: (202) 662-1025
Fax: (202) 662-1032
E-mail: aidsproject@abanet.org
Internet: www.abanet.org/irr/aidsproject/home.html.

American Public Health Association (APHA)
800 I Street, NW
Washington, DC 20001
Phone: (202) 777-2742 or
TTY (202) 777-2500
Fax: (202) 777-2534
Internet: www.apha.org.

American School Health Association (ASHA)
P.O. Box 708
Kent, OH 44240
Phone: (330) 678-1601
Fax: (330) 678-4526
E-mail: asha@ashaweb.org
Internet: www.ashaweb.org

Association for Supervision and Curriculum Development (ASCD)
1703 North Beauregard Street
Alexandria, VA 22311-1714
Phone: (703) 578-9600 or (800) 933-ASCD
Fax: (703)-575-5400
Internet: www.ascd.org

Association of State and Territorial Health Officials (ASTHO)
1275 K Street, N.W., Suite 800
Washington, D.C. 20005-4006
Phone: (202) 371-9090
Fax: (202) 371-9797
Internet: www.astho.org

CDC Division of Adolescent and School Health
4770 Buford Highway, NE, Mail Stop K-31
Atlanta, GA 30341-3724
Phone: (888) 231-6405
E-mail: HealthyYouth@cdc.gov
Internet: www.cdc.gov/nccdphp/dash.

CDC Division of HIV/AIDS
1600 Clifton Road, NE, Mail Stop E-49
Atlanta, GA 30333
Voice recording and fax information system:
(888) 232-3228
E-mail: hivmail@cdc.gov
Internet: www.cdc.gov/hiv/dhap.htm

CDC National Institute of Occupational Safety and Health (NIOSH)
Phone: (800) 356-4674
Fax: (513) 533-8573
Fax-on-demand: (888) 232-3299
E-mail: pubstaft@cdc.gov
Internet: www.cdc.gov/niosh

CDC National Prevention Information Network
P.O. Box 6003
Rockville, MD 20849
Phone: (800) 458-5231
TTY: (800) 243-7012 TTY
Fax-on-demand service: (800) 458-5231
E-mail: info@cdcnpin.org
Internet: www.cdcnpin.org

CDC National STD and AIDS Hotline
American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709
Phones: (800) 342-AIDS English
(800) 344-SIDA Spanish
TTY: (800) 243-7889
E-mail: hivnet@ashastd.org
Internet: www.ashastd.org

Center for Law and Education (CLE)
1875 Connecticut Avenue, NW, Suite 510
Washington, DC 20009
Phone: (202) 986-3000
Fax: (202) 986-6648
E-mail: cle@cleweb.org
Internet: www.cleweb.org

Center for AIDS Prevention Studies (CAPS)
AIDS Research Institute
University of California, San Francisco
74 New Montgomery, Suite 600
San Francisco, CA 94105
Phone: (415) 597-9100
Fax: (415) 597-9213
E-mail: CAPSWeb@psg.ucsf.edu
Internet: www.caps.ucsf.edu

Central Michigan University Educational Materials Center
139 Combined Materials Building
Mt. Pleasant, MI 48859
Phone: (800) 214-8961
Fax: (989) 774-3943
E-mail: emc@cmich.edu
Internet: www.emc.cmich.edu

Comprehensive Health Education Foundation
22323 Pacific Highway South
Seattle, WA 98198
Phone: (800) 323-2433
Fax: (206) 824-3072
Internet: www.chef.org

Council for Exceptional Children (CEC)
1110 North Glebe Road, Suite 300,
Arlington, VA 22201-5704
Phone: (888) CEC-SPED
TTY: (703) 264-9446 (text only)
Fax: (703) 264-9494
Internet: www.cec.sped.org

Council of Chief State School Officers (CCSSO)
One Massachusetts Ave., N.W., Suite 700
Washington, D.C. 20001-1431
Phone: (202) 408-5505
Fax: (202) 408-8072
Internet: www.ccsso.org

Council of School Attorneys (see National School Boards Association)

Education Commission of the States (ECS)
707 17th Street, #2700
Denver, CO 80202-3427
Phone: (303) 299-3600
Fax: (303) 296-8332
E-mail: ecs@ecs.org
Internet: www.ecs.org

Education Development Center (EDC)
55 Chapel Street
Newton, MA 02458-1060
Phone: (617) 969-7100
Internet: www.edc.org

Education Law Association
Mail Drop 0528
300 College Park
Dayton, Ohio 45469
Phone: (937) 229-3589
Fax: (937) 229-3845
E-mail:ela@udayton.edu
Internet: www.educationlaw.org

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
Phone: (800) 321-4407
Internet: www.etr.org

Gay, Lesbian, and Straight Education Network
121 West 27th Street, Suite 804
New York, New York 10001-6207
Phone: (212) 727-0135
Fax: (212) 727-0254
E-mail: glsen@glsen.org
Internet: www.glsen.org

Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
Phone: (800) 656-4533
Fax: (650) 854-4800
Internet: www.kff.org

HIV/AIDS Treatment Information Service
U.S. Department of Health and Human Services
P.O. Box 6003
Rockville, MD 20849
Phones: (800) HIV-0440 or
TDD: (800) 243-7012
Internet: www.hivatis.org

NAMES Project Foundation AIDS Memorial Quilt
1413 K Street, NW, 7th Floor
Washington, 20005
Phone: (202) 216-4993
Internet: www.aidsquilt.org

National Alliance of State and Territorial AIDS Directors (NASTAD)
444 North Capitol Street, N.W., Suite339
Washington, D.C. 20001
Phone: (202) 434-8090
Fax: (202) 434-8092
Internet: www.nastad.org

National AIDS Fund
Workplace Resource Center
1030 15th Street NW, Suite 860
Washington, D.C., 20005
Phone: (888) 234-AIDS
E-mail: info@aidsfund.org
Internet: www.aidsfund.org/workplac.htm

National Association of People with AIDS (NAPWA)
1413 K Street, N.W., Seventh Floor
Washington, D.C. 20005
Phone: (202) 898-0414
Fax: (202) 898-0435
E-mail: napwa@napwa.org
Internet: www.napwa.org

National Association of School Nurses (NASN)
P.O. Box 1300
Scarborough, ME 04074
Phone: (207) 883-2117
Fax: (207) 883-2683
E-mail: nasn@nasn.org
Internet: www.nasn.org

National Association of School Psychologists (NASP)
4340 East–West Highway, Suite 402
Bethesda, MD 20814
Phone: (301) 657-0270
Fax: (301) 657-0275
TDD: (301) 657-4155
E-mail: nasp@naspweb.org
Internet: www.naspweb.org

National Association of Social Workers (NASW)
750 First Street NE, Suite 700
Washington, DC 20002-4241
Phone: (800) 638-8799
Internet: www.naswdc.org

National Association of State Boards of Education (NASBE)
277 South Washington Street, Suite 100
Alexandria, VA 22314
Phone: (703) 684-4000
Publications: (800) 220-5183
Fax: (703) 836-2313
E-mail: healthy@nasbe.org
Internet: www.nasbe.org/healthyschools.mgi

National Association of State Directors of Special Education (NASDSE)
1800 Diagonal Road, Suite 320
Alexandria, VA 22314
Phone: (703) 519-3800
TDD: (703) 519-7008
Fax: (703) 519-3808
Internet: www.nasdse.org

National Center for Health Education
72 Spring Street, Suite 208
New York, NY 10012
Phone: (212) 334-9470
Fax: (212) 334-9845
E-mail: nche@nche.org
Internet: www.nche.org

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847
Phone: (800) 729-6686
TDD: (800) 487-4889
Fax: (301) 468-6433
E-mail: info@health.org
Internet: www.health.org.

National Coalition of Advocates for Students (NCAS)
100 Boylston Street, Suite 737
Boston, MA 02116
Phone: (617) 357-8507
Internet: www.ncas1.org

National Education Association (NEA)
Health Information Network
1201 16th Street NW, Suite 521
Washington DC 20036
Phone: (202) 822-7570
Fax: (202) 822-7775
Automated Resource Line: (800) 718-8387
E-mail: info@neahin.org
Internet: www.neahin.org

National Federation of State High School Associations (NHFS)
P.O. Box 690
Indianapolis, IN 46206
Phone: (317) 972-6900
Fax: (317) 822-5700
Internet: www.nfhs.org

National Information Center for Children and Youth with Disabilities (NICHCY)
P.O. Box 1492
Washington, D.C. 20013
Phone: (800) 695-0285
TDD: (202) 884-8200
E-mail: nichcy@aed.org
Internet: www.nichcy.org

National Minority AIDS Council (NMAC)
1931 13th Street, N.W.
Washington, DC 20009
Phone: (202) 483-6622
Fax: (202) 483-1135
E-mail: info@nmac.org
Internet: www.nmac.org

National Network for Youth
1319 F Street, N.W., Suite 401
Washington, D.C. 20004
Phone: (202) 783-7949
Internet: www.nn4youth.org

National PTA
330 North Wabash Avenue, Suite 2100
Chicago, IL 60611-3690
Phone: (800) 307-4782
Fax: (312) 670-6783
E-mail: info@pta.org
Internet: www.pta.org

National School Boards Association (NSBA)
1680 Duke Street
Alexandria, VA 22314
Phone: (703) 838-6722
Fax: (703) 683-7590
E-mail: info@nsba.org
Internet: www.nsba.org/schoolhealth

National School Public Relations Association (NSPRA)
15948 Derwood Road
Rockville, MD 20855
Phone: (301) 519-0496
Fax: (301) 519-0494
Internet: www.nspra.org

Office for Civil Rights (OCR), U.S. Department of Education
Mary E. Switzer Building
330 C Street, SW
Washington, D.C. 20202
Phone: (800) 421-3481
TDD: (877) 521-2172
Fax: (202) 205-9862
E-mail: OCR@ed.gov
Internet: www.ed.gov/ocr

Office of Family Policy Compliance, U.S. Department of Education
600 Independence Avenue, S.W., Room 1366
Washington, D.C 20202-4605
Phone: (202) 260-3887
Internet: www.ed.gov/offices/OM/fpco

Office of Minority Health Resource Center, U.S. Department of Health and Human Services
P.O. Box 37337
Washington, D.C. 20013
Phone: (800) 444-6472
E-mail: info@omhrc.gov
Internet: www.omhrc.gov/omhrc

Office of Special Education Programs (OSEP), U.S. Education Department
330 C Street, S.W.
Mary E. Switzer Building
Washington, DC 20202
Internet: www.ed.gov/offices/OSERS/OSEP

Safe and Drug-Free Schools Program, U.S. Education Department
Phone: (202) 260-3954
Internet: www.ed.gov/offices/OESE/SDFS/

Sexuality Information and Education Council of the U.S. (SIECUS)
130 West 42nd Street, Suite 350
New York, NY 10036-7802
Phone: (212) 819-9770
Fax: (212) 819-9776
E-mail: siecus@siecus.org
Internet: www.siecus.org

Social Security Administration (SSA)
6401 Security Blvd.,
Baltimore, MD 21235-0001
Phone: (800) 772-1213
TTY: (800) 325-0778
Internet: www.ssa.gov

UNAIDS Information Centre
20, avenue Appia
CH-1211 Geneva 27
Switzerland
Phone: (+4122) 791 3666
Fax: (+4122) 791 4187
E-mail unaids@unaids.org
Internet: www.unaids.org

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Appendix B: STATE INFORMATION SOURCES

State	*AIDS Hotline*	*OSHA Consulting*	*HIV Education*
ALABAMA	800-228-0469	205-348-3033	334-242-8199
ALASKA	800-478-2437	907-269-4957	907-465-8719
AMERICAN SAMOA			684-633-1246
ARKANSAS	800-342-2437	501-682-4522	501-324-9740
ARIZONA	800-342-2437	602-542-1695	602-542-8728
CALIFORNIA	800-367-2437	415-703-5270	916-657-5255
COLORADO	303-782-5186 (Denver) 800-252-2437 (other)	303-866-6616	303-866-6685
CONNECTICUT	800-203-1234	860-566-4550	860-566-6980
DELAWARE	800-422-0429	302-761-8219	302-739-4676
DIST. COLUMBIA	202-332-2437 800-322-7432 (Metro DC)	202-576-6339	202-889-4467
FLORIDA	800-352-2437	813-974-9962	850-488-7835
GEORGIA	800-551-2728	404-884-2643	404-651-9406
GUAM	671-735-7137	671-475-0136	671-475-0448
HAWAII	800-321-1555	808-586-9100	808-394-1335
IDAHO	800-926-2588	208-426-3283	208-332-6950
ILLINOIS	800-243-2437	312-814-2337	217-782-2826
INDIANA	800-848-2437	317-232-2688	317-232-9142
IOWA	800-445-2437	515-281-7629	515-281-4804
KANSAS	800-342-2437	785-296-7476	785-296-6716
KENTUCKY	800-342-2437	502-564-6895	502-564-3791
LOUISIANA	800-992-4379	225-342-9601	225-219-4452
MAINE	800-851-2437	207-624-6460	207-287-5930
MARYLAND	800-638-6252	410-880-4970	410-767-0305
MASSACHUSETTS	800-235-2331	617-727-3982	781-338-3603
MICHIGAN	800-872-2437 800-750-8336 (teen line)	517-322-1809 (health) 517-332-1809 (safety)	517-335-7252
MINNESOTA	800-248-2437	612-297-2393	612-592-8842

State	*AIDS Hotline*	*OSHA Consulting*	*HIV Education*
MISSISSIPPI	800-826-2961	601-987-3981	601-359-2359
MISSOURI	800-533-2437	314-751-3403	314-751-3805
MONTANA	800-233-6668	406-444-6418	406-444-1963
NEBRASKA	800-782-2437	402-471-4717	402-471-4359
NEVADA	800-842-2437	702-486-9140	775-687-9173
NEW HAMPSHIRE	800-752-2437	603-271-2024	603-271-3889
NEW JERSEY	800-624-2377	609-292-3923	609-292-9615
NEW MEXICO	800-545-2437	505-827-4230	505-827-1805
NEW YORK	800-872-2777	518-457-2238	518-486-6090
NORTH CAROLINA	800-342-2437	919-807-2905	919-715-1748
NORTH DAKOTA	800-782-2437	701-328-5188	701-328-2753
NORTHERN MARIANA ISLANDS			670-664-3726
OHIO	800-332-2437	614-644-2631	614-466-9540
OKLAHOMA	800-535-2437	405-528-1500	405-521-6645
OREGON	800-777-2437	503-378-3272	503-378-5585
PENNSYLVANIA	800-662-6080	412-357-2396	717-772-0067
PUERTO RICO	800-981-5721	809-754-2171	787-759-2000
RHODE ISLAND	800-726-3010	401-222-2438	401-222-4600
SOUTH CAROLINA	800-322-2437	803-734-9614	803-734-8076
SOUTH DAKOTA	800-592-1861	605-688-4101	605-773-6808
TENNESSEE	800-525-2437	615-741-7036	615-532-6260
TEXAS	800-299-2437	512-804-4640	512-463-4326
UTAH	800-366-2437	801-530-6901	801-538-7606
VERMONT	800-882-2437	802-828-2765	802-828-5151
VIRGIN ISLANDS	809-342-2437	340-772-1315	340-774-8168
VIRGINIA	800-533-4148	804-786-6359	804-225-4543
WASHINGTON	800-272-2437	360-902-5638	360-586-0245
WEST VIRGINIA	800-642-8244	304-558-7890	304-558-8830
WISCONSIN	800-334-2437	608-266-8579 (health) 262-523-3040 (safety)	608-266-7921
WYOMING	800-327-3577	307-777-7786	307-686-0317

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Appendix C: HIV TRANSMISSION FACTS

Research has revealed a great deal of valuable medical, scientific, and public health information about HIV and AIDS. The ways in which HIV can be transmitted have been clearly identified. Unfortunately, some widely dispersed information does not reflect the conclusions of scientific findings. The Centers for Disease Control and Prevention (CDC) provides the following information to help correct a few commonly held misperceptions about HIV:

Transmission

HIV is spread by sexual contact with an infected person, by needle-sharing among injecting drug users, or, less commonly (and now very rarely in countries where blood is screened for HIV antibodies [including the U.S.]), through transfusion of infected blood or blood-clotting factors. Babies born to HIV-infected women may become infected before or during birth, or through breast-feeding after birth.

In the health care setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood gets into the worker's bloodstream through an open cut or splashes into a mucous membrane (e.g., eyes or inside of the nose). There has been only one demonstrated instance of patients being infected by a health care worker; this involved HIV transmission from an infected dentist to six patients. Investigations have been completed involving more than 22,000 patients of 63 HIV-infected doctors and dentists, and no other cases of this type of transmission have been found.

Some people fear that HIV might be transmitted in other ways; however, no scientific evidence to support any of these fears has been found. If HIV were being transmitted through other routes (for example, through air or insects), the pattern of reported AIDS cases would be much different from what has been observed, and cases would be occurring much more frequently in persons who report no identified risk for infection. All reported cases suggesting new or potentially unknown routes of transmission are promptly and thoroughly investigated by state and local health departments with the assistance, guidance and laboratory support from CDC; no additional routes of transmission have been recorded, despite a national sentinel system designed to detect just such an occurrence.

The following paragraphs specifically address some of the more common misperceptions about HIV transmission.

HIV in the Environment

Scientists and medical authorities agree that HIV does not survive well in the environment, making the possibility of environmental transmission remote. HIV is found in varying concentrations or amounts in blood, semen, vaginal fluid, breast milk, saliva and tears. In order to obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the number of infectious viruses by 90 to 99 percent within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood and other body fluids reduces the theoretical risk of environmental transmission to that which has been observed—essentially zero.

Incorrect interpretation of conclusions drawn from laboratory studies have alarmed people unnecessarily. Results from laboratory studies should not be used to determine specific personal risk of infection because 1) the amount of virus studied is not found in human specimens or anyplace else in nature; and 2) no one has been identified as infected with HIV due to contact with an environmental surface.

Additionally, since HIV is unable to reproduce outside its living host (unlike many bacteria or fungi, which may do so under suitable conditions), except under laboratory conditions, it does not spread or maintain infectiousness outside its host.

Household and Other Settings

Although HIV has been transmitted between family members in a household setting, this type of transmission is very rare. These transmissions are believed to have resulted from contact between skin or mucous membranes and infected blood.

To prevent even such rare occurrences, precautions should be taken in all settings—including the home—to prevent exposures to the blood of persons who are HIV infected, at risk for HIV infection, or whose infection and risk status are unknown. For example, hands and other parts of the body should be washed immediately after contact with blood, and surfaces soiled with blood should be disinfected appropriately. Practices that increase the likelihood of blood contact, such as sharing of razors and toothbrushes, should be avoided. Needles and other sharp instruments should be used only when medically necessary and handled according to recommendations for health care settings.

There is no known risk of HIV transmission to co-workers, clients, or consumers from contact in industries such as food service establishments. Food service workers known to be infected with HIV need not be restricted from work unless they have other infections or illnesses (such as diarrhea or hepatitis A) for which any food service worker, regardless of HIV infection status, should be restricted. The Public Health Service recommends that all food service workers follow recommended standards and practices of good personal hygiene and food sanitation.

Kissing

Casual contact .through closed-mouth or "social" kissing is not a risk for transmission of HIV. Because of the theoretical potential for contact with blood during open-mouthed kissing, CDC recommends against engaging in this activity with an infected person. However, no cases of AIDS reported to CDC can be attributed to transmission through any kind of kissing.

Saliva, Tears, and Sweat

HIV has been found in saliva and tears in only minute quantities from some AIDS patients. It is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be transmitted by that body fluid. HIV has not been recovered from the sweat of HIV-infected persons. Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.

Insects

From the onset of the HIV epidemic, there has been concern about transmission of the virus by biting and blood-sucking insects. However, studies conducted by researchers at CDC and elsewhere have shown no evidence of HIV transmission through insects—even in areas where there are many cases of AIDS and large populations of insects such as mosquitoes. Lack of such outbreaks, despite intense efforts to detect them, supports the conclusion that HIV is not transmitted by insects.

The results of experiments and observations of insect biting behavior indicate that when an insect bites a person, it does not inject its own or a previous victim's blood into the new victim. Rather, it injects saliva. Such diseases as yellow fever and malaria are transmitted through the saliva of specific species of mosquitoes. However, HIV lives for only a short time inside an insect and, unlike organisms that are transmitted via insect bites, HIV does not reproduce (and, therefore, cannot survive) in insects. Thus, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites.

There is also no reason to fear that a biting or blood-sucking insect, such as a mosquito, could transmit HIV from one person to another through HIV-infected blood left on its mouth parts. Two factors combine to make infection by this route extremely unlikely—first, infected people do not have constant, high levels of HIV in their bloodstreams and, second, insect mouth

parts do not retain large amounts of blood on their surfaces. Further, scientists who study insects have determined that biting insects normally do not travel from one person to the next immediately after ingesting blood.

Effectiveness of Condoms

The proper and consistent use of latex condoms when engaging in sexual intercourse—vaginal, anal, or oral—can greatly reduce a person's risk of acquiring or transmitting sexually transmitted diseases, including HIV infection.

Under laboratory conditions, viruses occasionally have been shown to pass through natural membrane ("skin" or lambskin) condoms, which contain natural pores and are therefore not recommended for disease prevention. On the other hand, laboratory studies have consistently demonstrated that latex condoms provide a highly effective mechanical barrier to HIV.

In order for condoms to provide maximum protection, they must be used consistently (every time) and correctly. Incorrect use contributes to the possibility that the condom could leak or break...

When condoms are used reliably, they have been shown to prevent pregnancy up to 98 percent of the time among couples using them as their only method of contraception. Similarly, numerous studies among sexually active people have demonstrated that a properly used latex condom provides a high degree of protection against a variety of sexually transmitted diseases, including HIV infection.

Condoms are classified as medical devices and are regulated by the Food and Drug Administration. Each latex condom manufactured in the United States is tested for defects, including holes, before it is packaged, and several studies clearly show that condom breakage rates in this country are less than 2 percent. Even when condoms do break, one study showed that more than half of such breaks occurred prior to ejaculation.

Latex condoms can provide up to 98–99 percent protection against pregnancy and most sexually transmitted diseases, including HIV infection, but only if they are used consistently and correctly.

For more detailed information about condoms, see CDC's fact sheet, "The Role of Condoms in Preventing HIV Infection and Other Sexually Transmitted Diseases" [available from the CDC National AIDS Clearinghouse].

The Public Health Service Response

The U.S. Public Health Service is committed to providing the scientific community and the public with accurate and objective information about HIV infection and AIDS. It is vital that clear information on HIV infection and AIDS be readily available to help prevent further transmission of the virus and to allay fears and prejudices caused by misinformation.

In addition to research on the virus and its transmission, the PHS program to prevent the spread of HIV/AIDS includes counseling, testing, and education. Through these programs, individuals who have engaged in high-risk behaviors can receive voluntary HIV-antibody testing for themselves and their partners, and those found to be infected can be counseled regarding preventive services and treatment options, as well as how to prevent transmission to others.

For more information:

CDC National AIDS Hotline:
English (800) 342-AIDS
Spanish: (800) 344-SIDA
Deaf: (800) 243-7889

CDC National AIDS Clearinghouse:
P.O. Box 6003, Rockville, MD 20849-6003

CDC National AIDS Hotline Training Bulletin #79, December 1993

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Appendix D: SUGGESTED POLICY TERMS

Policy language needs to be precise and accurate if it is to communicate what is intended, provide clear guidance, and minimize confusion and differing interpretations. One's choice of words can communicate respect or scorn.

Outdated, inaccurate, or inappropriate terms	*Recommended terms*
AIDS *For purposes of education policy it does not matter whether a person is medically diagnosed with the advanced stage of HIV infection.*	HIV INFECTION *Broadly includes every stage of infection and illness. Education policy does not need to distinguish between HIV infection and AIDS.*
AIDS CARRIER *Often perceived as stigmatizing, and not scientifically accurate.*	PERSON LIVING WITH HIV OR AIDS *Not considered stigmatizing.*
AIDS-RELATED COMPLEX (ARC) *Refers to a stage of HIV infection when symptoms occur but AIDS has not been diagnosed. This term is not officially defined or recognized by the CDC and is now rarely used in the medical community.*	SYMPTOMATIC HIV INFECTION *More accurate.*
AIDS TEST *This shorthand term is misleading because the tests most often used do not detect the virus itself, only antibodies to the virus.*	HIV ANTIBODY TEST *More accurate.*
AIDS VICTIM *Implies helplessness, and a moral judgment about innocence and guilt.*	PERSON LIVING WITH HIV OR AIDS *Implies that the person is still in control of his or her own life.*
AIDS VIRUS *Misleading: a person infected with the human immunodeficiency virus might not have AIDS.*	HIV, or THE VIRUS THAT CAUSES AIDS *More accurate.*
BODY FLUID *Vague use of this term can cause confusion. It is usually better to specify exactly which fluids are meant.*	BLOOD, SEMEN, BREAST MILK, VAGINAL SECRETIONS *These can contain HIV in concentrations sufficient to cause infection.* SALIVA, SWEAT, TEARS *These have not been shown to cause infection.*
CONDOM *Condoms made of lambskin do not prevent HIV transmission.*	LATEX CONDOM, FEMALE CONDOM *Can prevent HIV transmission if used correctly and consistently.*

Continued

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Outdated, inaccurate, or inappropriate terms	*Recommended terms*
CONTAGIOUS *An infectious disease capable of being transmitted by casual contact .between people through normal, day-to-day contact. Colds, flu, or measles are contagious. In contrast, HIV is not transmitted through casual contact or in public places like schools.*	COMMUNICABLE *Any infectious disease that can be transmitted from one person to another, including HIV infection.*
DORMANT *HIV is never truly dormant: at every stage of infection HIV is active within the lymph system and continuously infects immune system cells.*	INCUBATION PERIOD *The time interval between initial exposure to infection and appearance of the first symptom of disease.*
GERM *A casual term that is not scientifically meaningful.*	PATHOGEN *Refers to any disease-causing agent including viruses, bacteria, fungi, and parasites.*
HIGH-RISK GROUP *No one is automatically at risk of HIV infection simply because of who he or she is.*	HIGH-RISK BEHAVIOR *The risk of infection arises from what a person **does**, not who he or she is.*
HIGH-RISK YOUTH *This stigmatizing term can make a young person feel that HIV infection is a matter of fate.*	YOUTH IN HIGH-RISK SITUATIONS *The focus needs to be on a person's conduct and environment.*
INTRAVENOUS DRUG *Drug use that risks HIV transmission does not always involve injection into veins.*	INJECTABLE DRUG *Broader, more accurate, and easier to understand.*
LATENT *See Dormant.*	CLINICAL LATENCY *The period of HIV infection when there are no observable symptoms, averaging ten years in adults.*
SAFE SEX *Self-contradictory. The only truly safe sex is consistent abstinence from sexual intercourse, that is, no sex at all.*	SAFER SEX *A set of techniques can reduce a person's risk of acquiring HIV, but never entirely eliminate it.*
SPREADING DISEASE *This phrase connotes a conscious intention to infect other people.*	TRANSMISSION OF AN INFECTIOUS AGENT *In contrast, this phrase puts the focus on the pathogen, not the person it is within.*

Reference: Glossary of HIV/AIDS-Related Terms, *HIV/AIDS Treatment Information Service, June 1995.*
Inspired by the Safe Choices Guide *of the National Network of Runaway and Youth Services*

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Appendix E: FEDERAL DISABILITY RIGHTS LAWS

Following are descriptions of some of the Federal laws that have implications for students or staff members who are living with HIV infection or AIDS. Congress occasionally amends laws such as these, and the executive branch periodically revises the implementing regulations. Court decisions also affect how these laws are implemented. Policymakers and administrators should always check the current legal parameters.

CIVIL RIGHTS PROTECTIONS FOR PERSONS WITH DISABILITIES

Both HIV infection and AIDS are defined as disabilities, and so federal civil rights laws intended to protect the rights of persons with disabilities fully apply.

Section 504 of the Rehabilitation Act of 1973 prohibits institutions that receive federal funds—which includes most public schools—from denying services or discriminating because of a disabling condition. The law therefore allows families legal recourse if a school denies or alters a student's education for no other reason than HIV infection. This includes a student's participation in a school-sponsored athletic program, club, transportation service, or any other activity. In practice this means, for example, that a school must allow a student with HIV infection to play in the school band if the student is "otherwise qualified," that is, if his or her musical skills meet the band's standard requirements. Similarly, a school cannot bar a student from riding a school bus because of HIV infection. School officials must not tolerate harassment of a student with HIV infection on school grounds.

> **Section 504 of the Rehabilitation Act of 1973**
>
> No otherwise qualified handicapped individual in the United States... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance...

The law protects *all* persons with disabilities, not just students, from discrimination in public institutions that receive federal funds. This means, for example, that at a parent-teacher conference a teacher cannot treat a parent with HIV infection any differently than others.

Section 504 goes beyond protecting those who actually have a disability. It also includes anyone who is "regarded as having an impairment." This means that individuals who are merely *perceived* to have HIV infection, or *treated as* having the infection are also protected from discrimination. A child who is rumored to be infected with HIV cannot be made to eat alone, for instance.

Section 504 also requires that every school district appoint a compliance officer to help implement the Rehabilitation Act.

The Americans with Disabilities Act of 1990 (commonly referred to as the ADA) builds upon and extends the anti-discrimination provisions of Section 504. Non-sectarian private schools, libraries, museums, auditoriums, and day care centers must conform to the requirements of the ADA whether or not they receive federal funds. Parochial schools and day care centers directly operated by religious organizations are exempt from the anti-

> **Section 504**
>
> The provision of an appropriate education is the provision of regular or special education and related aids and services that...are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met... Implementation of an individualized education program developed in accordance with the Education of the Handicapped Act [now IDEA] is one means of meeting the standard...

discrimination provisions (but the law's employment protections *do* still apply: see Section 2 in Chapter II).

The regulations drawn up by the U.S. Department of Education's Office of Civil Rights (OCR) to implement Section 504 specifically address school settings, while the regulations for ADA are more general and are administered by other federal agencies. OCR recommends that schools use the Section 504 regulations to interpret the ADA.

One area in which the ADA goes further than Section 504 is protecting from discrimination those with a "known relationship or association" with a disabled person, such as family members, friends, or anyone else who associates with a person living with HIV infection. This means, for example, that a school's administration has to intervene if they notice that a student is being verbally abused because of a relative's HIV infection. Or, if a performance group has a member with HIV infection and a scheduled school appearance is canceled out of fear of HIV, *everyone* in the group has grounds to sue.

EDUCATIONAL RIGHTS

The regulations drawn up under Section 504, the federal civil rights protection law, mandate that every student with a disability—including every student with HIV infection—be provided a "free, appropriate public education" that meets his or her educational needs to the same extent as other students. The law's regulations generally require that a student with a disability remain in the regular educational environment—with the assistance of supplementary aids or services if needed—unless someone can demonstrate that the child cannot be appropriately educated there.

If a student cannot be educated in a regular classroom and needs specialized services of some sort, Section 504 requires the school to determine the child's educational needs on an individual basis. The evaluation and placement procedures must conform to those specified in the U.S. Education Department's regulations. The school must then provide the placement, aids, and services identified as necessary to meet the student's individual needs. The federal government does not assist with funding to pay for these services, unless the child is also eligible under IDEA (below).

> School officials can develop an Individual Education Program to conform to Section 504, but it is not a requirement.

Developing an individualized education program (IEP) plan is one way to satisfy a school's legal obligations under Section 504. An individualized health plan (IHP) is another (see Section 1). Whatever the set of procedures used, a school must periodically revisit and revise a plan as often as necessary to ensure that the student's educational needs are continually being met.

Parents and guardians have due process rights under Section 504. A school must notify a student's parent or guardian of actions regarding the identification, evaluation, and

placement of the student, and the parent/guardian has the right to appeal the school's decisions. The appeals process must be fair and prompt. In practice, it is rare that a school proceeds to plan and provide special services unless the student's parent or guardian fully participate in the process and give written permission.

IDEA, the **Individuals with Disabilities Education Act**, is a federal program that provides funds to school districts to help the districts implement their obligations to disabled students. The guidelines defining a student's eligibility for the program are more specific than those in Section 504, which is broadly written to protect everyone with a disability. A student is deemed eligible under IDEA who qualifies by age, *and* has an impairment specified in the law, *and* requires special educational or related services because of that impairment.

The Individuals with Disabilities Education Act

[The goal is]...to assure that all children with disabilities have available to them...a free appropriate public education which emphasizes special education and related services designed to meet their unique needs, to assure that the rights of children with disabilities and their parents or guardians are protected, to assist states and localities to provide for the education of all children with disabilities, and to assess and assure the effectiveness of efforts to educate children with disabilities.

Children and youth with developmental disabilities, such as those with damage to their young nervous systems caused by HIV, are nearly always eligible under IDEA. Any student is eligible who has "limited strength, vitality or alertness, due to chronic or acute health problems... that adversely affects a child's educational performance." In practice, if a student is ill and deemed to need services under Section 504, the student is probably also eligible under IDEA. Eligibility means the student's school can get federal funding assistance to educate the student.

Section 504 and the ADA are civil rights protection laws. IDEA is a funding program.

IDEA is intended to help students with disabilities obtain a free, appropriate public education "in the least restricted environment." This means that, to the greatest extent feasible, schools must educate a student with HIV infection with other children in the regular classroom.

A widely known administrative feature of IDEA is the requirement that a school prepare an individualized education program (IEP) document and update it at least annually, using a process detailed in the federal regulations. The IEP sets out a plan for special educational and related services designed to meet the unique educational needs of a student with a disability. Only an IEP team (often called an Admissions, Review, and Dismissal Committee), has the legal authority to enroll a student in a federally funded special education program, or to change a student's existing IEP.

A parent, guardian, or school staff member can trigger an IEP planning process. School leaders should be careful not to let program funding incentives influence their decisions about a student's identification, placement, or services. A student must have a genuine learning, physical, and/or mental impairment to justify providing federally funded services to the student.

Schools are required to make strenuous good faith efforts to involve parents or guardians in every aspect of the IEP development and implementation process. Schools have to

provide opportunities to examine records and appeal decisions. As with the Section 504 procedures described earlier, in practice it is unusual that a school proceeds to provide services without the permission of the student's parent or guardian.

For more information on these laws, consult the resources listed earlier on page 16.

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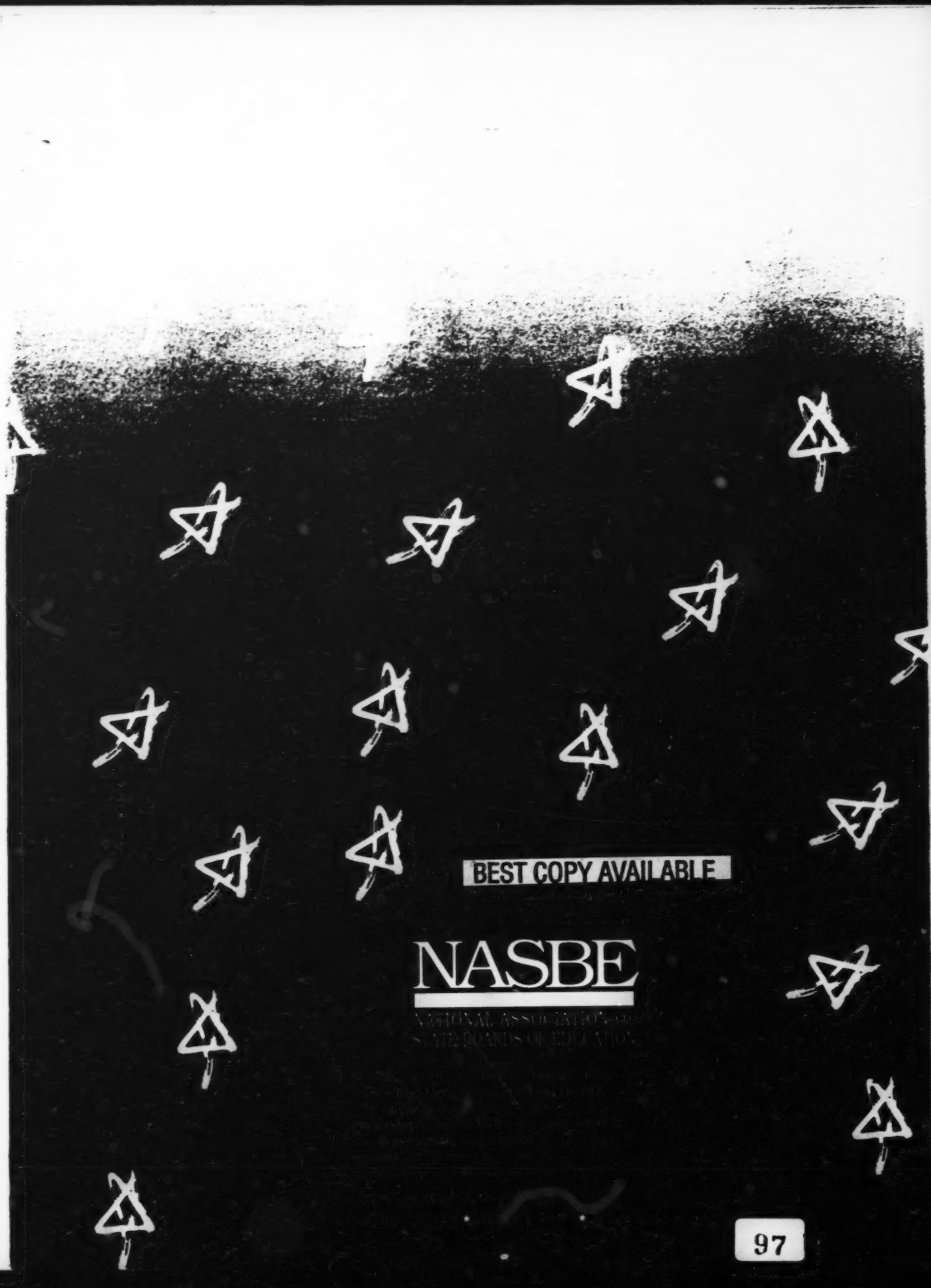
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